State of Nebraska
Department of Health and Human Services
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

Request For Requirements - Medicaid Managed Care

Request for Proposal (RFP) Number 112209 O3
Response Deadline: July 1, 2022 2:00 p.m. Central Time

PUBLIC COPY

Healthy Blue

Improving Health Outcomes for Children

Healthy Blue contributes to Omaha Healthy Kids Alliance's mission to strengthen quality of life for children in Omaha.

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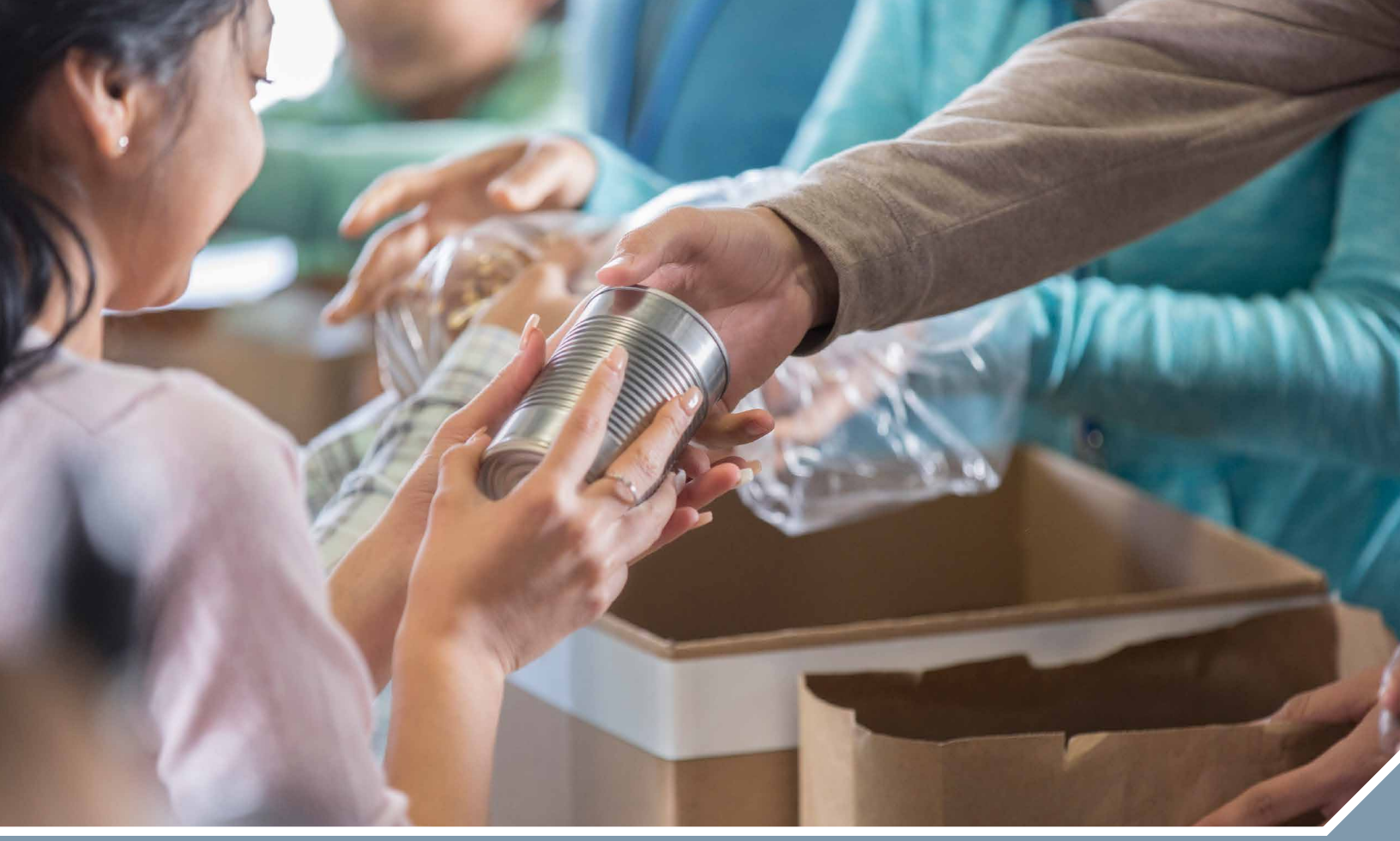
Healthy Blue



Providing Food as Medicine

Healthy Blue partners with organizations across the state, including the Food Bank of Lincoln and the United Way of Western Nebraska, to provide healthy food to families statewide.

Transmittal Letter

Healthy Blue

July 1, 2022

Mr. Greg Walklin
Department of Health and Human Services
301 Centennial Mall South
Lincoln, Nebraska 68509

Dear Mr. Walklin,

On behalf of Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue (Healthy Blue), I am proud to present our proposal to continue to serve Nebraska Heritage Health members beginning on July 1, 2023, in response to the State of Nebraska, Department of Health and Human Services' (DHHS') Request for Proposal (RFP) Solicitation Number: 112209 O3.

Healthy Blue has been your trusted partner, delivering health benefits to more than 113,000 Nebraska Medicaid enrollees since 2017, and is a wholly owned subsidiary of Elevance Health, Inc. (previously known as Anthem, Inc.). Effective June 28, 2022, our parent company Anthem, Inc. changed its name to Elevance Health to reflect the next important chapter in our journey, as it better reflects our business and the company we are today. ***Elevance Health is the combination of elevate + advance to convey our commitment to innovation and our pursuit of moving health forward — elevating the importance of whole health and advancing health beyond health care.*** Our parent company continues to be a leading health benefits organization with more than 31 years of experience administering Medicaid and other government-sponsored programs and currently operates Medicaid and CHIP programs in 25 and 19 other markets, respectively.

Our proposal represents our continued commitment to partner with the MLTC and reflects our vision to transform the whole health of Nebraska through greater integration of social needs into care delivery to improve health outcomes and advance equity. Further, our Proposal affirms our established processes and procedures to deliver Nebraska Heritage Health services consistent with the requirements established by MLTC and includes details about our past successes as a committed partner. Throughout our Proposal, you will find the following indicators that reinforce our commitment to the Nebraska Heritage Health program, the members and providers we serve, the local stakeholders and community-based organizations with whom we partner, and the State of Nebraska.

Acknowledgements

Healthy Blue is authorized to transact business in the State of Nebraska and remains in compliance with all Nebraska Secretary of State Registration requirements. We formally accept that we will meet all obligations, standards, and all other requirements detailed within each section of the RFP, corresponding attachments, and addenda. Additionally, Healthy Blue confirms the receipt of the following three addenda to the RFP issued by DHHS as of the date of response submission:

- Addendum One for Request for Proposal Number 112209-O3: May 16, 2022
- Addendum Two for Request for Proposal Number 112209-O3: May 16, 2022
- Addendum Three for Request for Proposal Number 112209-O3: June 6, 2022

Transmittal

As Healthy Blue's President and Chief Executive Officer, I am proud to be authorized to legally bind Healthy Blue and able to respond to DHHS about the information included within this Proposal. Please do not hesitate to contact me using the following information:

Dr. Robert Rhodes, President and Chief Executive Officer
Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue
10040 Regency Circle
Omaha, Nebraska 68114
(402) 875-7948
Robert.Rhodes@healthybluene.com

Healthy Blue has been honored to serve the State of Nebraska and we are proud of our enduring legacy, improving the health of our neighbors in the communities we serve. I speak for the many dedicated Healthy Blue employees who have proudly served here at home over the years when I say that we hope to earn the opportunity to continue to serve Nebraska Heritage Health and the State and play a role in driving lasting improvements in the health, quality of life, and productivity of the State we all call home.

Sincerely,

Dr. Robert Rhodes, CEO
Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue

Request for Confidential Treatment

Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue (Healthy Blue) has designated the following information in our response to Solicitation Number RFP 112209 O3 as trade secret or proprietary or commercial information, as defined by Nebraska Revised Statute § 84-712.05. If released, this information would give advantage to business competitors, including to competitors currently operating in Nebraska, and those who may do so in the future, and would serve no public purpose. Healthy Blue obtains independent actual or potential economic value from the information not being generally known to, and not being readily ascertainable by proper means, by our competitors, who would obtain economic value from its disclosure or use by providing information to them that is not generally available.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
A.1-A.10 – Pgs. 16-49, 53-55, 61-111	Regulatory actions and sanction information; customer reference contact information; resumes	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
Attachment VI.A.2-2: Banking Reference – Pg. 1	Account number information	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 1 – Pg. 1	Risk-bearing relationships and delegation strategy; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 2 – Pgs. 3-4	Member incentive programs; program performance data and strategies to improve performance; provider contracting strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 3 – Pg. 5	Program performance data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 4 – Pg. 6	Disenrollment statistics	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 7 – Pg. 12	Regulatory reporting statistics	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 9 – Pgs. 14-16	Strategies and programs to enhance services to members; unique stakeholder relationships	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 12 – Pgs. 20, 22	Detailed operational infrastructure, and staffing information and strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 13 – Pg. 23	Detailed operational infrastructure and staffing information and strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 14 – Pgs. 24-26	Staffing information and strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 19 – Pgs. 61-73	Value-added services strategies and program descriptions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 20 – Pgs. 74-77	Program performance data and improvement trends; member education innovations and strategies; member incentives, value-based purchasing programs; unique stakeholder collaborations; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 21 – Pgs. 78-80	Telehealth strategies; staffing resources; pilot programs and unique partnerships; value-based purchasing and provider incentive programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 22 – Pgs. 81, 83	Program performance data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
No. 23 – Pgs. 85-86	Program performance data and trends; value based purchasing and provider incentives	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 24 – Pgs. 87-88	Staffing resources and program oversight strategy; training programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 25 – Pgs. 89-92, 93-94	Call center statistics; training programs; member need assessment strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 27 – Pg. 98	Member outreach enhancements	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 28 – Pgs. 100-104	Member outreach enhancements; member incentives and outcomes; enhancements in call center staffing and responses; value added services; technology enhancements; telehealth strategies; provider incentive programs; community-based support strategies; performance improvement program outcome data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 29 – Pg. 105	Staffing resources; telehealth strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 30 – Pgs. 106-110	Member outreach enhancements and statistics; value added services; utilization data; technology enhancements; member incentives; unique stakeholder relationships and programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 31 – Pgs. 111-113	Member grievance and appeal resolution statistics; value added services	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 32 – Pg. 114-115	Member outreach enhancements	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 33 – Pgs. 116-118, 120	Provider network development plan and growth strategies; provider network composition; staffing resources; unique provider relationships and programs for the upcoming contract; details on scholarship programs; value based purchasing strategies and information	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 34 – Pgs. 121-122	Staffing resources and process for provider outreach and oversight with program requirements	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 35 – Pgs. 124-125	Value-based purchasing and provider incentive programs; telehealth strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 37 – Pgs. 128-130	Value-based purchasing programs; staffing resources and provider engagement strategies; telehealth strategies; IT solutions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 38 – Pgs. 132-133	Provider contracting and issue resolution strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 40 – Pg. 137	Claim payment timeliness statistics	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 41 – Pg. 139	Staffing resources and provider outreach strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
No. 42 – Pgs. 143-145	Call center statistics; provider satisfaction data; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 44 – Pg. 151	Information technology enhancements	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 45 – Pg. 153	Process flow for timely provider complaint resolution	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 46 – Pg. 156	Tools and strategies to support utilization of electronic health records	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 47 – Pgs. 157-158	Provider education strategies; provider incentive programs; telehealth strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 48 – Pgs. 159-162	Provider education strategies; staffing resources; strategies for soliciting and addressing provider feedback; provider satisfaction data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 49 – Pg. 209	Internal subcontractor data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 50 – Pgs. 238, 244	Claims and encounter accuracy and timeliness statistics; subcontractor corrective action plan and performance example	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 51 – Pgs. 252-253, 255-263	Call center innovations and strategies; value added services; programs and strategies to address chronic conditions; programs and strategies to address substance use disorders and social determinants of health; IT solutions; case studies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 52 – Pgs. 266-267	Predictive modeling tools and methodology; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 53 – Pgs. 269-270, 272-273	Utilization statistics; call center innovations and strategies; value added services	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 54 – Pgs. 274-275	Social determinants of health strategies and supports; staffing resources; education programs; provider incentive programs; strategies to enhance member access to resources; call center innovations and strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 56 – Pgs. 278-279	Strategies and programs to address homelessness and housing instability; staffing resources; member outreach strategies; training programs; social determinants of heath initiatives	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 57 – Pgs. 280-281	Care Management strategies, tools and programs; staffing resources; value added services descriptions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 58 – Pgs. 282-283	Care management strategies; staffing resources; value added services	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 59 – Pg. 284	value added services; strategic future educational programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
No. 60 – Pgs. 285-289	Service coordination strategies; staffing resources; telehealth strategies; utilization trends and improvements achieved; performance data and trends; strategies and programs to promote safe and successful transitions; Strategies to prevent behavioral health readmissions; performance improvement project outcomes; provider incentive programs.	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 61 – Pgs. 292-293	Data analytics tools and reports generated; provider incentive programs and value based purchasing	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 62 – Pg. 294	Unique stakeholder relationships; medication management programs and strategies; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 63 – Pgs. 296-297	Program outcome data and trends; member incentives; provider incentive programs; predictive models; care management programs and strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 64 – Pgs. 298, 302-303, 306	Quality improvement strategies; outcome data and improvement trends; value added services; staffing resources; provider outreach strategies;	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 65 – Pgs. 309-310	Performance improvement projects and improvement trends; examples of successful quality improvement interventions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 66 – Pgs. 311-314	Performance improvement strategies and tools and data utilized; quality improvement outcomes and trends; population health strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 68 – Pg. 318	Staffing resources; unique stakeholder relationships and initiatives	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 69 – Pg. 321	Performance improvement project outcomes and trends	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 70 – Pg. 324	Member survey results	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 73 – Pg. 329	Strategies to improve rural access to care; value added services; telehealth strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 74 – Pgs. 330-331	Provider directory and data improvements, tools and information technology solutions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 75 – Pg. 333	Initiatives aimed at increasing service utilization	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 77 – Pgs. 338-339, 342	Program data, outcomes and trends; innovations and solutions aimed at reducing administrative burden on providers; provider incentive strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 80 – Pgs. 350-353	Program data, outcomes and trends; cost savings achieved; digital strategies and solutions; value-based incentive programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 82 – Pg. 356	Value-based purchasing strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
No. 84 – Pgs. 360-361	Utilization statistics and improvement trends; strategies to improve service utilization	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 85 – Pgs. 362-366	Program data, outcomes, and trends; value added services; member incentives; initiatives to decrease emergency room utilization; provider network composition and availability; service utilization data; telehealth strategies; predictive models; provider incentive programs and outcome data; unique stakeholder collaborations; strategies aimed at appropriate use of medications; behavioral health strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 86 – Pgs. 368-370	Medication management programs, strategies, and interventions; controlled substance utilization monitoring strategies	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 88 – Pgs. 375-377	Medication management programs, strategies and outcomes; value added services	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 89 – Pgs. 379	Data analytics tools and reports; strategies to increase access to services	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 90 – Pg. 380	Program integrity savings achieved	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 91 – Pgs. 383-384	Examples of SIU interventions	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 92 – Pg. 385	Fraud, waste, and abuse savings	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 93 – Pg. 389	Savings generated from subrogation activities	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 94 – Pgs. 390-394	Value based purchasing programs and strategies; provider incentive programs; staffing resources; strategies aimed to increase provider participation in provider incentive programs	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 95 – Pg. 397	Pharmacy program data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 98 – 402, 405, 407, 409, 411, 413, 415, 417, 419, 421, 423	Data interfaces and system infrastructure, and flow charts	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 99 – Pgs. 424-426	Information security safeguards and infrastructure	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 100 – Pgs. 427-428	Internal systems performance data; internal systems infrastructure and processes	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 102 – Pgs. 431-433	Information security management infrastructure, processes, procedures, and safeguards	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 103 – Pgs. 434-436	Internal systems infrastructure and processes; business continuity components, processes and procedures; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 104 – Pgs. 437-438	Claims payment performance data; internal system structure and description	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

Location in Bid (Tab/Question/Page)	Description/Explanation	Statutory Basis for Confidentiality
No. 105 – Pgs. 439-441	Claims payment performance data and improvements; operational performance processes, process flows, and strategies; staffing resources	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 106 – Pg. 443	Sample member letter	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 108 – Pg. 446	Operational performance data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 109 – Pgs. 447-448, 450	Encounter submission process flow and operational performance data; claim submission data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 111 – Pgs. 454-472	Operational performance data and trends; performance improvement project description; internal data evaluation reports; population health analytics data; value-based purchasing and incentive program data	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
No. 114 – Pgs. 480-492	Innovations and strategies to address social barriers and economic disparities, and to improve health outcomes	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
Attachment V.I.33-1: Plan for Developing an Adequate Network – Pgs. 2-42	Network development plan	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
Attachment V.L.52-1: Health Risk Assessments – Pgs. 2-69	Health risk assessment reports and questionnaires	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
Attachment V.M.74-1: Sample Quality Reports – Pgs. 1-13	Quality Reports	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.
Attachment V.N.82-1: Prior Authorization List – Pgs. 1-97	Prior authorization list	Trade Secret or proprietary or commercial information. Nebraska Revised Statute § 84-712.05.

CALLED TO CARE - Robert Rhodes, MD, Chief Executive Officer

I have lived in Nebraska the last 28 years, and I have worked in Medicaid for 3 years. I am passionate about helping to lead and work with a dedicated team that has great heart for our members. When I was CMO, I took pride in pushing past barriers to help members get the care they needed at the right time and place. One example was getting a young member urgent transportation into a non-participating ophthalmology specialist the next day to help save their vision. Later, we worked to get the provider into our network- so that was a great feeling of a team helping on several levels. Additionally, I am the Founder of Clinic with a Heart, a free health care clinic in Lincoln that serves the homeless, under-insured and uninsured. In that role, I have seen the effects of how social determinants like food insecurity and financial stress can determine someone's health. I want to lead with a servant heart to make a difference for all of those that are more vulnerable.

CALLED TO CARE: As a practicing Family Physician in Nebraska for 25 years, I knew Medicaid patients were a special group. Their life stories were amazing and many motivated me or gave me pause to understand ALL that they had endured or were enduring. Sometimes they needed just a little more time, someone to listen and to show them someone cared. I remember that is who I work to help now on a wider scale.

Original Request for Proposal for Contractual Services

Healthy Blue

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING INK OR VIA DOCUSIGN

CONTRACTOR:	Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue
COMPLETE ADDRESS:	8055 O Street, Suite 300 Lincoln, NE 68510
TELEPHONE NUMBER:	402-310-8842
EMAIL ADDRESS:	Robert.Rhodes@healthybluene.com
DATE:	06/30/2022
SIGNATURE:	DocuSigned by: Robert B Rhodes, MD 09179DA959D2452...
TYPED NAME & TITLE OF SIGNER:	Dr. Robert Rhodes, Chief Executive Officer

Improving Maternal Wellness

Healthy Blue supports pregnant members and new parents by providing supplies, resources, and community baby showers.

Bidder Proposal Point of Contact

Healthy Blue

Form A
Bidder Proposal Point of Contact
Request for Proposal Number 112209 O3

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue
Bidder Address:	8055 O Street, Suite 300 Lincoln, NE 68510
Contact Person & Title:	Dr. Robert Rhodes, Chief Executive Officer
E-mail Address:	Robert.Rhodes@healthybluene.com
Telephone Number (Office):	402-875-7948
Telephone Number (Mobile):	402-310-8842

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue
Bidder Address:	8055 O Street, Suite 300 Lincoln, NE 68510
Contact Person & Title:	Dr. Robert Rhodes, Chief Executive Officer
E-mail Address:	Robert.Rhodes@healthybluene.com
Telephone Number (Office):	402-875-7948
Telephone Number (Mobile):	402-310-8842

CALLED TO CARE - Tami DeBonis, Medical Management Coordinator

I've been with Healthy Blue for the past 1.5 years and, as a nurse, I'm passionate about maternal health and supporting Black, Indigenous and People of Color, low income and teen moms to get the resources they need to have safe and healthy pregnancies and postpartum experiences. I find opportunities and work to support their growth to help members. For example, giving grant funding to statewide doula organizations to help grow their infrastructure to better support Nebraska residents to promote better maternal and infant outcomes.

CALLED TO CARE: As a teen mother, I relied on the support of State programs including Medicaid for my daughter, subsidized childcare (so I could finish school), and WIC. That experience, along with my experience as a labor nurse, paved the way for the roles I've been in most recently. Having this life experience and being able to place myself in our members' shoes is a blessing in my career and one that is not lost on me.

Section II.

TERMS AND CONDITIONS

Healthy Blue

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. The State of Nebraska is soliciting proposals in response to this solicitation. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

The bidders should submit with its proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contract resulting from this solicitation shall incorporate the following documents:

1. Request for Proposal, including attachments and addenda;
2. Amendments to the solicitation;
3. Written Questions and answers;
4. Contractor's proposal (Contractor's response to the solicitation and properly submitted documents); and
5. Amendments and addenda to the contract, including the Service Contract Award.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendments and addenda, including the Service Contract Award with the most recently dated amendment or addenda, respectively, having the highest priority, 2) Amendments to solicitation 3) Questions and answers, 4) The original solicitation document and any addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Contractor and State shall each identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered electronically, personally, or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the identified contract manager, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or five (5) calendar days following deposit in the mail.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

C. NOTICE (POC)

The State reserves the right to appoint a Procurement Contracts Officer's Representative to manage [or assist the Procurement Contracts Officer in managing] the contract on behalf of the State. The Procurement Contract Officer's Representative will be appointed in writing, and the appointment document will specify the extent of the Procurement Contract Officer's Representative authority and responsibilities. If a Procurement Contract Officer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Procurement Contract Officer's Representative. The Procurement Contract Officer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK

The awarded bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, this RFP must meet all applicable federal law, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska into compliance with federal law shall be deemed part of the scope of the requested bid.

G. CHANGE ORDERS OR SUBSTITUTIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

H. VENDOR PERFORMANCE REPORT(S)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The State may document any instance(s) of products or services delivered or performed that exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. DHHS may contact the Contractor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Contractor.

I. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired.The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

K. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, penalties, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, reimbursement requests or other penalties from regulatory authorities, and attorney fees and expenses ("the claims"), sustained by or asserted against the State for personal injury, death, property loss or damage, noncompliance with public records laws or other information requests, or noncompliance with governing Medicaid laws and regulations arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this solicitation.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be an established dollar amount of fifty million dollars ($50,000,000) The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the contract has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

P. LIQUIDATED DAMAGES

Liquidated damages are referenced in Section V.V. Contract Non-Compliance and Attachment 10 – Liquidated damages.

Q. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to the terms of Section V.C. Business Requirements and Section V.D. Staffing Requirements. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

R. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

S. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

T. OFFICE OF PUBLIC COUNSEL (Statutory)
If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

U. LONG-TERM CARE OMBUDSMAN (Statutory)
Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

V. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. Pursuant to 42 CFR § 438.708 the State may enroll that contractor's members in other MCOs or provide their benefits through other options included in the Medicaid State Plan if the State, at its sole discretion determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Section 1932, 1903(m) or 1905(t) of the Social Security Act.

a. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

b. The State will provide the Contractor with timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

c. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

d. In accordance with 42 CFR § 438.710 , the State will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.

i. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

ii. The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

e. The State will notify Medicaid members enrolled in the MCO in writing, consistent with 42 CFR § 438.710 and 438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

f. The State may terminate the contract immediately for the following reasons:

i. If directed to do so by statute;

ii. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;

iii. A trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;

iv. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;

v. An involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law , to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;

vi. A voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

vii. Contractor intentionally discloses confidential information;

viii. Contractor has or announces it will discontinue support of the deliverable;

ix. Second or subsequent documented "vendor performance report" form deemed unacceptable by the State Purchasing Bureau;

x. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract; and

xi. In the event funding is no longer available.

W. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Upon contract closeout for any reason the Contractor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

Girl Scout Spirit of Nebraska

Healthy Blue is improving the health and wellbeing of Girl Scouts, statewide, by teaching them how to eat healthy and stay active, and celebrating their achievements with the *Healthy Blue, Healthy You* patch.

We are proud to support individual Girl Scout members and troops in leading healthy lifestyles, by creating safe spaces for troop meetings, establishing camp scholarships for underserved youth, and sponsoring Health and Wellness community service projects across the state in partnership with Girls Scout Spirit of Nebraska.

Section III.

CONTRACTOR DUTIES

Healthy Blue

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees; and
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html
2. The completed United States Attestation Form should be submitted with the solicitation response.
3. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all subcontracts for goods and services to be covered by any contract resulting from this solicitation.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the proposal. Cash discount periods will be computed from the date of receipt of a properly

executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

F. PRICES

This section only applies to Section V. AA. FFS CLAIMS MANAGEMENT AND PROCESSING – OPTIONAL SERVICES in the scope of work.

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the contractor, F.O.B. destination named in the solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

All prices, costs, and terms and conditions submitted in the proposal shall remain fixed and valid commencing on the opening date of the proposal until the contract terminates or expires.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

G. COST CLARIFICATION

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

H. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any subcontractor to commence work until the subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within five (5) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and five (5) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

4. REINSURANCE

- **a.** The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.
- **b.** All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of thirty (30) calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Statute 44-3292 et seq. and other relevant laws.
- **c.** The MCO must maintain reinsurance agreement throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.
- **d.** The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

5. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written

by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

6. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Inssounurance and Commercial Automobile Liability Insurance as shall protect Contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$10,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$10,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

7. EVIDENCE OF COVERAGE

The Contractor shall furnish a certificate of insurance coverage complying with the above requirements prior to beginning work to the identified contract manager.

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

8. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

K. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

If Contractor breaches the contract or anticipates breaching the contract the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, and may include a request for a waiver of the breach if so desired. The State may, at its discretion, temporarily or permanently waive the breach. By granting a temporary waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

L. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

N. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the contract award shall not be issued without prior written approval from the State.

O. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

P. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Q. CLEAN AIR ACT (REGULATORY)

Contractor shall ensure that it complies with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. §§ 7401 et seq., and the Federal Water Pollution Control Act as amended, 33 U.S.C. §§ 1251 et seq.

R. LOBBYING (REGULATORY)

No federal appropriated funds shall be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract or (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, Contractor shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

S. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Contractor shall not, at any time, recruit or employ any person who evaluated proposals received for this RFP.

The prohibition under this section shall last two (2) years after the Contract Execution Date.

CALLED TO CARE - Amy Lauby, RN-BSN, Care Manager II, NICU and Pediatric

A Nebraska native, I have worked as a Medicaid Care Manager for the past 3.5 years, using my professional and personal experience to help families navigate barriers to managing their children's care. My goal is to help them efficiently and effectively manage their child's needs and provide some relief for the burden this can be, so they can focus on the joy and love their child brings. Recently, I worked with our team to help a mother obtain transportation to the NICU so she could bond with her child, supported her through the transition to palliative care at home, and am assisting her to successfully navigate the child's needs. She has expressed much gratitude for my assistance.

CALLED TO CARE: Medicaid support is very personal to me. My oldest son had many medical complexities due to his premature birth. He was a Medicaid recipient from birth to when he passed at age 8. My experiences as a NICU mom and mother of a medically complex child fuel my passion for helping other families in similar situations. It helps me to be empathetic as they experience challenges along the way and has given me the knowledge to help them navigate their child's ongoing and ever changing needs.

Section IV.

PAYMENT

Healthy Blue

IV. PAYMENT

A. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

B. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

C. PAYMENT (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
DS RBR			

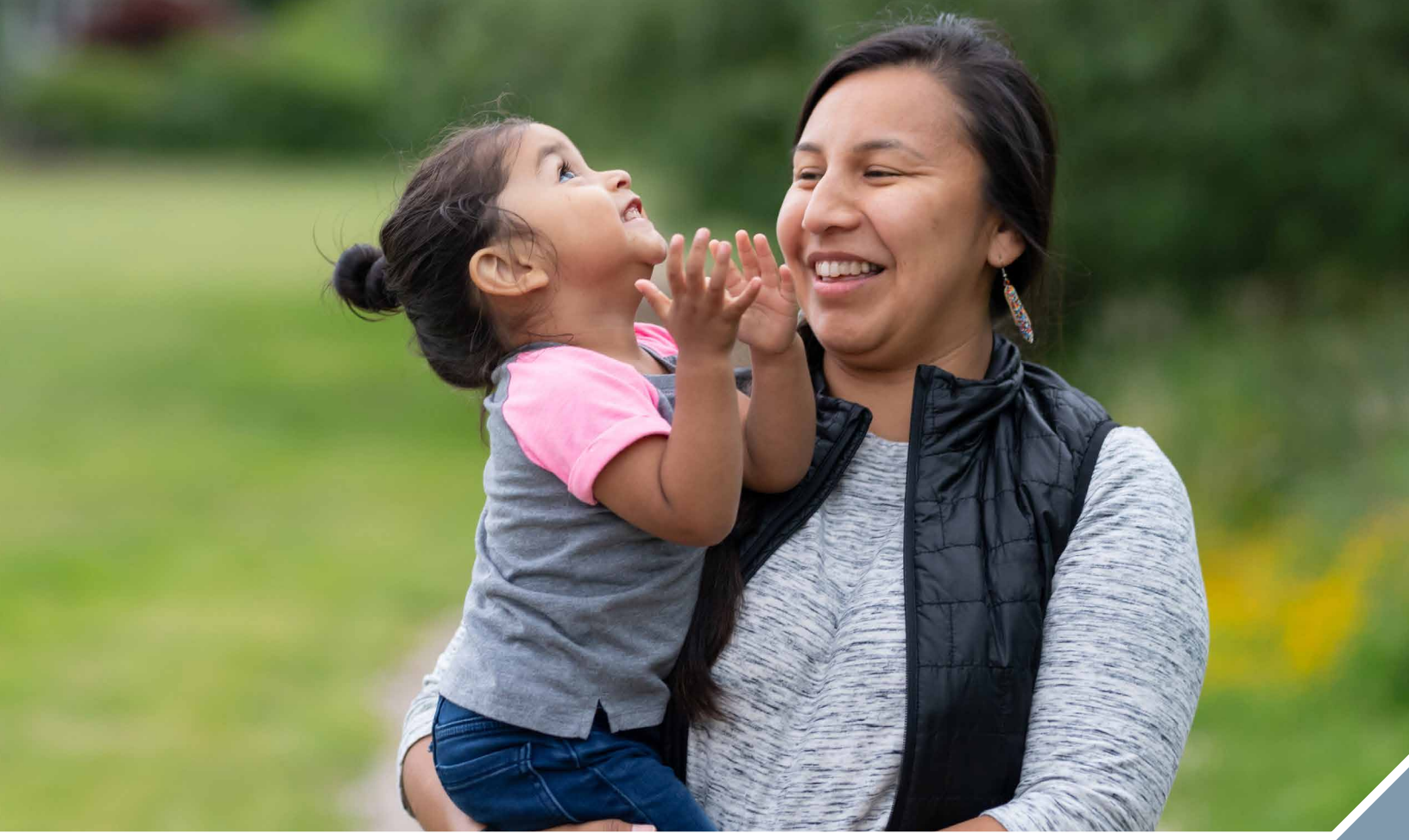
Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

D. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2401 through 81-2408).

E. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.



Supporting Tribal Communities

Healthy Blue hosts monthly diaper drives for members who live in Tribal communities.

Section V.

PROJECT DESCRIPTION AND SCOPE OF WORK

Healthy Blue

V. PROJECT DESCRIPTION AND SCOPE OF WORK

Healthy Blue has clearly identified and addressed the requirements of Section V. Project Description and Scope of Work throughout our responses to Section VI. Proposal Instructions: A. Corporate Overview, and B. Technical Approach.

CALLED TO CARE - Audrey Rocheleau, Community Relations Specialist 2

I have lived in Nebraska all my life and have worked at Healthy Blue for the past 3 years. We are able to assist members and help them lead better lives. Whether it is our food pantries, where we help families that did not know how they were going to put food on the table until the next paycheck, or informing members at our COVID clinics about value-added services, we make a real difference in members' lives.

CALLED TO CARE: I am passionate about my family, my faith, and having a servant's heart. My joy is helping others and I'm privileged to be able to do that every day at my job.

Section VI.

PROPOSAL INSTRUCTIONS

Healthy Blue

Advancing Community Transit

Healthy Blue supports North Fork Area Transit in its mission to provide affordable, accessible transportation to rural Nebraskans.

VI.A. Corporate Overview

Healthy Blue

A.1

Bidder Identification and Information

Our full company name is Community Care Health Plan of Nebraska, Inc. d/b/a Healthy Blue. Healthy Blue is the trade name of Community Care Health Plan of Nebraska, Inc., an independent licensee of Blue Cross and Blue Shield Association. Healthy Blue operates as a domestic, for-profit corporation organized to do business in Nebraska.

Our main office is located at:
10040 Regency Circle, Suite 100
Omaha, Nebraska 68114

We also rebranded as Healthy Blue, effective November 6, 2020, representing a formal joint venture between Anthem Partnership Holding Company, LLC, a subsidiary of Elevance Health, Inc. (previously known as Anthem, Inc. as detailed later in this section), one of the nation's leading Medicaid health care companies, and Blue Cross and Blue Shield of Nebraska (BCBSNE), a trusted choice for health care in Nebraska with more than 80 years of experience serving members in the state. As Healthy Blue, we have direct access to the operational and fiscal support, experience, and best practices of two parent companies. As an incumbent serving members since the beginning of Heritage Health, we are committed to transparency and remaining accountable to the State as well as to members, providers, and stakeholders. Our capacity to serve Nebraskans goes beyond performing functions of the RFP — Healthy Blue focuses on improving the lives of members and building healthier communities across the state.

Backed by the strength of a joint venture between Elevance Health and BCBSNE, we bring a powerful alliance that offers a premier health solution for Medicaid members and a long-standing local presence that members recognize and trust and that the State can rely on. We turn this alliance into practice through regular and ongoing communication and collaboration. We hold quarterly Joint Operating Committee meetings so that our leaders can discuss, ideate, review, and share local population health initiatives, lessons learned, and best practices. For example, through our committee discussions, we identified initiatives that included a comprehensive Doula program for pregnant moms in collaboration with the University of Nebraska Medical Center and the Malone Center, a nonprofit dedicated to racial and socioeconomic equality. Through these discussions, Healthy Blue and BCBSNE agreed to donate a combined $40,000 to the March of Dimes to help co-sponsor a member-focused educational program called the Supportive Pregnancy Care program that will go live this summer.

Incorporation Date

We were incorporated on October 20, 2015 as WellCare of Nebraska, Inc., a subsidiary of Comprehensive Health Management, Inc. d/b/a WellCare of Nebraska. Following WellCare's merger with Centene Corporation, we were acquired by Anthem, Inc. (now Elevance Health, Inc.), on January 23, 2020, and changed our legal name to Community Care Health Plan of Nebraska, Inc. WellCare of Nebraska remains a registered trade name.

Corporate Name Change

Effective June 28, 2022, our parent company Anthem, Inc. changed its name to Elevance Health to reflect the next important chapter in our journey, as it better reflects our business and the company we are today. Elevance Health is the combination of elevate + advance to convey our commitment to innovation and our pursuit of moving health forward — elevating the importance of whole health and advancing health beyond health care. Our parent company continues to be a leading health benefits organization with more than 31 years of experience administering Medicaid and other government-sponsored programs and currently operates Medicaid and CHIP programs in 25 and 19 other markets, respectively.

A.2

Financial Statements

Healthy Blue has shown exceptional capacity for growth and the financial stability necessary to successfully partner with the State since we began serving Nebraskans five years ago. We provide the requested most recent financial information in our Healthy Blue Financial Statements, provided as Attachment VI.A.2-1. Our representative who is fiscally responsible for our financial organization is:

Name: James Cecil
10040 Regency Circle
Suite 100
Omaha, Nebraska 68114
Phone Number: (515) 414-1444

Healthy Blue has $92 million in Capital and Surplus as of December 31, 2021 per the Annual National Association of Insurance Commissioners (NAIC) filings. This capital reserve reflects a surplus over the requirement of $53 million, which equates to 2.4 times the requirement of 200% of Authorized Control Level Risk Based Capital (ACL RBC). Table VI.A.2-1 underscores the stability and financial strength of our organization.

Table VI.A.2-1. Healthy Blue Brings Capital Strength and Stability.

Net Worth Analysis – Measures	Healthy Blue Value	Description
(Dollars in 000s)		
Total Capital and Surplus	$92,017	Per 12/31/2021 Annual NAIC Filing
Authorized Control Level (ACL) Risk Based Capital (RBC)	$19,279	Per 12/31/2021 Annual NAIC Filing
RBC Ratio Against ACL	477.3%	Total Adjusted Capital divided by ACL RBC
Minimum Required Level of 200% ACL	$38,558	Adopted Minimum Capital Level
Excess of 200% of ACL Requirement – $	$53,549	Total Adjusted Capital Minus 200% of ACL

Net Worth Analysis – Measures	Healthy Blue Value	Description
(Dollars in 000s)		
Multiple Over Net Worth Requirement	2.4	
Total Capital and Surplus	$100,145	Per 3/31/2022 Quarterly NAIC Filing

Our parent company, Elevance Health, Inc. (previously known as Anthem, Inc.), provides us with any necessary financial backing via access to capital markets, and we can leverage their financial strength and resources. In 2021, the combined ACL RBC ratio across insurance and HMO operating subsidiaries averaged approximately 480%, which is 2.4 times federal and State requirements. As of December 31, 2021, our parent company held $1.2 billion in cash and investments.

We have additional support and backing from Blue Cross and Blue Shield of Nebraska (BCBSNE), which holds 5% ownership in Healthy Blue and helps strongly position us to continue serving Nebraska for years to come. Under the terms of our partnership agreement, BCBSNE will share in any required additional funding up to 5% of their stake.

Though BCBSNE is a private firm, as a wholly-owned subsidiary of a publicly held ultimate parent (Elevance Health, Inc.) we have provided a copy of the corporation's most recent audited financial reports and statement as Attachment VI.A.2-1, Healthy Blue Financial Statements, of this proposal.

Banking Reference

Healthy Blue provides a banking reference as Attachment VI.A.2-2: Banking Reference.

Disclosure of Any and All Judgments, Pending or Expected Litigation, or Other Financial Reversals

Healthy Blue has not had any judgments, pending or expected litigation, or any other real or potential financial reversals that might materially affect the viability or stability of the organization. None of these conditions are known to exist.

A.3

Change of Ownership

Community Care Health Plan of Nebraska, d/b/a Healthy Blue does not anticipate any change in ownership or control of company during the 12 months following the proposal due date. We acknowledge that any change of ownership requires notification to the State and comply with this requirement.

A.4

Office Locations

Healthy Blue's main office responsible for performance is located at:
10040 Regency Circle
Suite 100
Omaha, Nebraska 68114

Our CEO, Dr. Robert Rhodes, works out of our Lincoln Corporate office and is ultimately accountable for all aspects of our health plan operations and performance pursuant to this contract. In addition, we maintain several locations across the state to reach members in their communities and to successfully administer the programs and services under our contract. Table VI.A.4-1 highlights our office locations, including our Welcome Rooms.

We operate five Welcome Rooms across Nebraska, which are storefront locations where members can stop by and be greeted by one of our Marketing and Community Relations Representatives who engage our members in face-to-face interaction and offer resources like classes, seminars, and educational materials. Our Welcome Rooms help our members access needed physical health, behavioral health, and SDOH resources and are an important way for us to solicit feedback on quality of care from the community.

Table VI.A.4-1. Healthy Blue's Offices Span Across the State.

Location Type	Location Address	City, State, Zip Code
Main Office	10040 Regency Circle, Suite 100	Omaha, Nebraska 68114
Corporate Office	8055 O Street, Suite 300	Lincoln, Nebraska 68510
Welcome Room	2910 K Street	Omaha, Nebraska 68107
Welcome Room	2621 5th Avenue	Scottsbluff, Nebraska 69361
Welcome Room	500 South 13th Street, Suite 200	Norfolk, Nebraska 68701
Welcome Room	2714 2nd Avenue, Suite A	Kearney, Nebraska 68845
Welcome Room	1625 N Street	Lincoln, Nebraska 68508

A.5

Healthy Blue's Strong Relationship and Activities with the State Over the Last Five Years

For the previous five years, Healthy Blue has contracted with the State to administer benefits and services for the Heritage Health program. We have served Heritage Health since the beginning and are proud to be a trusted partner whose local leaders have collaborated with the State to help achieve a healthier Nebraska. ***In addition to our one-on-one interactions with the State, Healthy Blue leadership actively participate in more than 50 workgroups and committees, working with multiple State agencies as well as other MCOs, providers, members, and community partners.*** Our local leadership contributes meaningful insight, analysis, and recommendations to State agencies and program partners. For example, over the course of our current Heritage Health contract (Contract Number 71164 04):

- Our Pharmacy Director, Shannon Nelson, PharmD spearheaded an effort to bring together all three MCOs to agree and use more consistent coverage for over-the-counter medications. This effort included working with the State to develop a data request form for pharmacy, so that all three MCOs submitted consistent data to the State. She also helped identify inconsistencies in the preferred drug list that needed corrections and notified the State proactively.
- We partnered with DHHS on a diabetes prevention program, a one-year longitudinal educational and accountability program to help support and educate members who diagnosed as pre-diabetic.
- We identified limitations in the State's medical necessity criteria for negative pressure wound therapy, which is an adjunct to basic wound care. We shared our findings with the State and worked collaboratively to get language updated in the criteria so that all Medicaid members could receive wound devices, when needed. In addition, Healthy Blue implemented our parent company's criteria for this therapy to help improve outcomes for members in managing and treating their chronic wounds.
- Our Behavioral Health Manager, Shannon Calabrese, worked with other members of the DHHS Health Oversight Committee to create a subcommittee that developed a trauma assessment for DHHS workers.
- We have also collaborated with the State during times of transition, such as the carve-in of Non-Emergency Medical Transportation benefits in 2019 and the expansion of Medicaid benefits in 2021 to help identify and resolve gaps or issues that arise.
- To help support education and information, DHHS has used our Welcome Rooms, located throughout the state, to host town halls and provide information to providers and members.
- Our team works collaboratively with State legislators to advance initiatives that promote better health outcomes for Medicaid members. For example, our Pharmacy Director worked with the State's Deputy Director on recommending legislative language around a pharmacy bill. In addition, during the legislative session, Healthy Blue's Government Relations Director, Wendy Hind, attends a weekly meeting with DHHS along with other MCOs to discuss important pieces of legislation.

Additional Contracts with the State

Other than our Heritage Health contract, Healthy Blue nor its predecessor or any Party named in our proposal has contracted with the State or had any business dealings with the State over the previous five years.

A.6

Employee Relations to the State

Healthy Blue hires the most qualified individuals to fulfill our contract requirements. Table VI.A.6-1 details Healthy Blue employees previously employed by the State within the past 12 months. We are unaware of any other Healthy Blue employees who were employed by the State in the last 12 months, and do not have any current Healthy Blue employees who are employed by the State.

Table VI.A.6-1. Healthy Blue's Staff Previously Employed by the State Within the Last 12 Months.

Name of Current Healthy Blue Employee	State Agency of Former Employment and Job Title	Separation Date
Jodi Payne	Department of Health and Human Services Former Job Title: Child and Family Services Specialist	August 13, 2021
Lacie Ward	Department of Health and Human Services Medicaid and Long-Term Former Job Title: DHHS Administrator I	August 18, 2021
Rebecca Nelms	Department of Health and Human Services Medicaid and Long-Term Care Former Job Title: Administrative Programs Officer I	October 14, 2021
Angie Ludemann	Department of Health and Human Services Children and Family Services Division Former Job Title: Well-Being Administrator	November 30, 2021

A.7

Contract Performance, Investigations or Sanctions

Healthy Blue, nor any of our proposed subcontractors, nor our organization's parent companies, affiliates, and subsidiaries have ever had a contract terminated for default during the past two years or had any contract terminated for convenience, non-performance, non-allocation of funds, or any other reason.

Healthy Blue has not been subject to a criminal or civil investigation by a state or federal agency during the past five years.

In the ordinary course of business, our parent company Elevance Health, Inc. (previously known as Anthem, Inc.) and its affiliates and subsidiaries have been subject to civil investigations by state and federal agencies, none which have had or expected to have an impact on the ability of Healthy Blue and our organization to perform services under this contract. We provide a listing of these matters in Table VI.A.7-1, none of which concern Medicaid business or our Medicaid affiliates. Additionally, unique to the state of California, our commercial affiliate has been subject to civil investigations by the California Department of Managed Health Care (DMHC) in the ordinary course of business, the majority of which stemmed from member grievances or provider payments disputes related to a single claim for services. While not relevant to Healthy Blue or our Medicaid business, we provide a listing of these matters in Table VI.A.7-2 out of an abundance of caution towards compliance and in furtherance of our commitment to transparency. ***If the DMHC identifies any system or systemic issues or deficiencies, the Blue Cross process is to take prompt action to remedy any such issue or deficiency.***

Our parent company, Blue Cross and Blue Shield of Nebraska, has not been subject to a criminal or civil investigation by a state or federal agency during the past five years.

Please refer to Table VI.A.7-3, which identifies all instances of non-compliance Healthy Blue, parent organizations, and affiliates have incurred as part of Medicaid managed care contracts within the past five years.

Table VI.A.7-1. Description of Parent Company and Affiliate Investigations.

Matter Number	Matter Name/Case Caption	Relevant Details	Status/Outcome
PRL-03876-18	Department of Labor Investigation of Anthem Health Plans, Inc. d/b/a Anthem Blue Cross & Blue Shield of Connecticut EBSA Case No. 31-036101	Now with Anthem's Avoidable ER review program in the news the DOL has issued this subpoena to obtain information about how ER claims were/are being processed from 2015 to present.	Active.
PRL-04045-18	Department of Health Care Services Monetary Sanctions	DHCS is sanctioning Anthem Partnership Plan $11.4 million for failure to send compliant Notices of Rights and failure to accurately report violations.	Closed – Resolved via Confidential Settlement.
PRL-04069-18	Anthem Health Plans of NH, Inc. d/b/a Anthem Blue Cross and Blue Shield EBSA Case No. 31-036305	DOL is conducting an investigation focused narrowly on ER services and reclassification to urgent care; behavioral health relating to obesity or morbid obesity and behavioral health related to findings "not subject to favorable modifications through therapy."	Active.
PRL-04160-19	Congressional Investigation: STLDI Plans/IHC	Congressional inquiry into short-term life health and disability insurance plans.	Closed 05/04/2022 – Congress issued a Report of Findings and Recommendations regarding information and data collected from 14 Short-Term Limited Duration Health Insurance plans and brokers ("STLDI"). None of the recommendations were specifically directed towards Anthem or Anthem-owned entities. Congress recommended 1) subject STLDI plans to ACA's consumer protections at the federal level, or 2) states should restrict STLDI.
PRL-04438-20	In the Matter of: Prescription Insulin Drub Pricing	CO AG CID into insulin pricing. Broad investigation of payors and manufacturers.	Closed 05/04/2022 – Colorado Department of Law issued report of investigation into insulin pricing as a result of CIDs to industry participants at all levels of the drug distribution chain and

Matter Number	Matter Name/Case Caption	Relevant Details	Status/Outcome
			recommendations to reduce the impact of rising insulin prices.
PRL-04469-20	Civil Investigative Demand 2020-EDCA-0013	CID from the E.D. of California US Attorney's office related to ACA 1202 payments by Blue Cross in California.	Active.
PRL-04483-20	Colorado Department of Regulatory Agencies, Colorado Civil Rights Division in re the matter of Jessica Freeman	Investigation into allegations of denial of claim based on discrimination due to transgender status.	Closed 01/05/022 – Resolved via Confidential Settlement.
PRL-04698-21	DOJ Civil HealthSun Investigation	DOJ Civil Investigation of Coding Practices at HealthSun based on an internal ethics report by a departing HealthSun employee.	Active.
PRL-04708-21	Customer Complaint Related to COVID-19 Testing Charges	California AG inquiry regarding member complaint over Anthem not covering 100% of COVID testing performed by non-par laboratory.	Active.
PRL-04714-21	Empire-Commercial/DFS Prompt Pay Penalties (#1190)	Prompt Pay Penalties.	Active.
PRL-04746-21	Empire-HealthPlus/DFS Prompt Pay Penalties (#1190)	"Prompt Pay Penalties Related Matter - PRL-04714-21."	Active.
CID-00008-21	In the matter of the IN Attorney General's Civil Investigative Demand to Anthem Insurance Companies, Inc. No 21-055	CID from the IN Attorney General related to how Anthem Insurance Companies, Inc. contracts with providers in Indiana for the relevant time period of Jan 1, 2010 to present	Active.
CID-00009-21	United States Department of Justice Civil Investigation Demand No. 21-694	USDJ served a CID on Freedom Health potentially related to a sales and marketing issue.	Active.
PRL-03480-17	United States of America v. Anthem, Inc.	US DOJ Investigation of Anthem, Inc. regarding risk adjustment claims to the Centers for Medicare and Medicaid Services ("CMS") under Medicare Parts C & D. In March 2020, the DOJ filed a civil lawsuit against Anthem following this investigation, which is active and is disclosed in Anthem's SEC Form 10-Q.	Active.
	Missouri DCI Recoupment Investigation	Audit/Exam by Missouri Department of Insurance of Healthy Alliance Life Insurance Company. Start Date 2/9/2021. Audit/Exam Scope: Cancellations/Terminations/ Reinstatements, Claims, Company Operations and Management, Complaints – Grievances/Appeals/Provider Disputes, Recovery Audit Contractor Review, Vendors, and Subcontractors.	Active.
	Missouri DCI Dental Premium Filing Investigation	Audit/Exam by Missouri Department of Insurance of Healthy Alliance Insurance Company. Start date 2/17/2021. Audit/Exam Scope: Actuarial, Marketing and Sales, Rates and Premiums, Underwriting.	Active.
	2021 NH Investigation – NHID #159861 Nonpayment Cancellation	Audit/Exam by New Hampshire Department of Insurance of Matthew Thornton Health Plan, Inc. Start Date 3/11/2021. Audit/Exam Scope: Cancellations/Terminations/ Reinstatements, Enrollment and Disenrollment.	Active.
	2021 NH Investigation – NHID #164473 Certified Nurse Midwife Reimbursement	Audit/Exam by New Hampshire Department of Insurance of Anthem Health Plans of New Hampshire, Inc. Start Date 4/13/2021. Audit/Exam Scope: Providers/Networks	Active.

Matter Number	Matter Name/Case Caption	Relevant Details	Status/Outcome
	2021 NH Investigation – NHID #163134 Provider Billing of COVID Tests	Audit/Exam by New Hampshire Department of Insurance of Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. Start Date 3/4/2021. Audit/Exam Scope: Claims, Complaints – Grievances/Appeals/Provider Disputes.	Active.
	2021 ME Investigation 2021-33251 Newborn Claim Processing	Audit/Exam by Maine Bureau of Insurance of Anthem Health Plans of Maine, Inc. Start Date: 9/15/2021. Audit/Exam Scope: Benefits, claims, Mandated Coverage.	Active.
	2022 MO DCI Certificate Language Investigation	Audit/Exam by Missouri Department of Insurance of Healthy Alliance Life Insurance Company and HMO Missouri, Inc. Start Date: 2/25/2022. Audit/Exam Scope: Contracts/EOCs and Form Filings.	Active.
	2021 NY DFS Testing Out-of-Network COVID-19 Testing	Audit/Exam by New York Department of Financial Services of Empire Health Choice Assurance, Inc. Audit/Exam Scope: Claims.	Active.
	2021 CT DOI Network Adequacy Survey	Audit/Exam by Connecticut Department of Insurance of Anthem Health Plans, Inc. Audit/Exam Scope: Providers/Networks. Corrective Action Plan Issued.	Active.
	2018 CO DOI Confidential Investigation Case No 8984	Audit/Exam by Colorado Department of Insurance of HMO Colorado, Inc. and Rocky Mountain Hospital and Medical Service, Inc., Start Date 1/18/2018. Audit/Exam Scope: Agent/Broker.	Closed. No findings or corrective action plans issued.
	2018 NHID investigation – Unfair Insurance Trade Practices	Audit/Exam by New Hampshire Department of Insurance of Matthew Thornton Health Plan, Inc. Start Date 2/7/2018. Audit/Exam Scope: Cancellations/Terminations/ Reinstatements, Correspondence (Member), Customer Service/Call Center Operations, Encounters, Enrollee Rights, Enrollment and Disenrollment.	Closed. No findings or corrective action plans issued.
	2018 CO DOI Med Supp Rate Adjustment Disabled Members upon Age 65	Audit/Exam by Colorado Department of Insurance of Rocky Mountain Hospital and Medical Service, Inc. Start Date 10/8/2018. Audit/Exam Scope: Enrollment and Disenrollment, Rates, and Premiums.	Closed. One finding related to unfiled rates. No corrective action plan issued. No fine assessed.
	2018 NY DOH Provider Network Data System Sanctioned Providers Analysis	Audit/Exam by New York Department of Health of Empire Health Choice HMO, Inc. Start Date 3/8/2019. Audit/Exam Scope: Providers/Networks.	Closed. One finding related to sanctioned providers. One eCAP issued related to the providers identified. No fine assessed.
	2019 VA Bureau of Insurance Investigation "ER Groups" OON ER Reimbursement	Audit/Exam by Virginia Bureau of Insurance of Anthem Health Plans of Virginia, Inc., and HealthKeepers, Inc. Start Date 9/4/2019. Audit/Exam Scope: Claims, Providers/ Networks.	Closed. No findings or corrective action plans issued.
	2019 VA BOI Alleged Violation of Fair Business Practices TF/FS	Audit/Exam by Virginia Bureau of Insurance of Anthem Health Plans of Virginia, Inc., and HealthKeepers, Inc. Start Date 8/23/2019. Audit/Exam Scope: Providers/Networks.	Closed. No findings or corrective action plans issued.
	2020 MO DCI Provider Directories Investigation	Audit/Exam by Missouri Department of Insurance of Healthy Alliance Life Insurance Company. Start Date 1/9/2020. Audit/Exam Scope: Claims, Contracts/EOCs and Form Filings, Correspondence (Provider), Customer Service/Call Center Operations, Marketing and Sales, Providers/Networks.	Closed. No findings or corrective action plans issued.
	VA 2020 Survey – Required Interactive Cost Comparison Tool	Audit/Exam by New Hampshire Department of Insurance of Matthew Thornton Health	Closed. One finding related to website compliance. No

Matter Number	Matter Name/Case Caption	Relevant Details	Status/Outcome
		Plan, Inc. Start Date 10/20/2020. Audit/Exam Scope: Systems and IT, Website Compliance.	corrective action plans or fines issued.
	2021 NH Investigation – NHID #164071 Drug Cost Share Assistance	Audit/Exam by New Hampshire Department of Insurance of Matthew Thornton Health Plan, Inc. Start Date 3/18/2021. Audit/Exam Scope: Formulary Administration, Prescription Drug Events (PDE).	Closed. No findings or corrective action plans issued.
	2020 NH Investigation – NHID #163455 Infusion Drug Prior Authorizations	Audit/Exam by New Hampshire Department of Insurance of Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. Start Date 2/11/2021. Audit/Exam Scope: Utilization Review and Management.	Closed. No findings or corrective action plans issued.
	2020 NH Investigation – NHID # 163319 Drug Prior Authorization Denial	Audit/Exam by New Hampshire Department of Insurance of Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. Start Date 3/23/2021. Audit/Exam Scope: Pharmacy, Utilization Review and Management.	Closed. No findings or corrective action plans issued.
	2021 NH Investigation – NHID # 163754 MH Benefits	Audit/Exam by New Hampshire Department of Insurance of Matthew Thornton Health Plan, Inc. Start Date 3/19/2021. Audit/Exam Scope: Behavioral Health, Benefits, Claims.	Closed. No findings or corrective action plans issued.
	2021 NH Investigation – NHID # 163733 Provider File Matching Error Denials	Audit/Exam by New Hampshire Department of Insurance of Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. Start Date 3/10/3021. Audit/Exam Scope: Providers/Networks.	Closed. No findings or corrective action plans issued.
	2022 MO DCI HealthLink HMO Utilization Review Reporting Investigation	Audit/Exam by Missouri Department of Insurance of HealthLink HMO, Inc. Start Date 2/4/2022. Audit/Exam Scope: Complaints – Grievances/Appeals/Provider Disputes, Reporting, Utilization Review and Management, Vendors, and Subcontractors.	Closed. No findings or corrective action plans issued.
	2022 MO DCI UniCare Utilization Review Reporting Investigation	Audit/Exam by Missouri Department of Insurance of UniCare Life & Health Insurance Company. Start Date 2/4/2022. Audit/Exam Scope: Complaints – Grievances/ Appeals/Provider Disputes, Reporting, Utilization Review and Management, Vendors, and Subcontractors.	Closed. No findings or corrective action plans issued.

Table VI.A.7-2. Description of California Affiliate Investigations.

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	06/08/2022	K. Operating at Variance with the EOC	Letter of Agreement	750,000.00
Blue Cross of California	06/08/2022	K. Operating at Variance with the EOC	Letter of Agreement	360,000.00
Blue Cross of California	06/06/2022	D. Financial Solvency and Audits, B. Claims, K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	40,000.00
Blue Cross of California	05/24/2022	K. Operating at Variance with the EOC, E. Grievance and Appeals, B. Claims, D. Financial Solvency and Audits	Letter of Agreement	15,000.00
Blue Cross of California	05/13/2022	D. Financial Solvency and Audits, K. Operating at Variance with the EOC, B. Claims, E. Grievance and Appeals	Letter of Agreement	15,000.00
Blue Cross of California	05/13/2022	W. Independent Medical Review	Letter of Agreement	20,000.00
Blue Cross of California	05/03/2022	E. Grievance and Appeals	Letter of Agreement	10,000.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	03/24/2022	D. Financial Solvency and Audits, B. Claims, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	03/14/2022	B. Claims, D. Financial Solvency and Audits	Letter of Agreement	5,000.00
Blue Cross of California	02/12/2022	N. Timely Access Reporting	Letter of Agreement	10,000.00
Blue Cross of California	02/08/2022	BB. Quality Assurance, H. Licensing Standards, M. Medical Surveys, I. Utilization Review	Letter of Agreement	50,000.00
Blue Cross of California	01/26/2022	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	01/26/2022	K. Operating at Variance with the EOC, D. Financial Solvency and Audits, B. Claims, E. Grievance and Appeals	Letter of Agreement	30,000.00
Blue Cross of California	01/04/2022	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	15,000.00
Blue Cross of California	12/07/2021	D. Financial Solvency and Audits, B. Claims	Letter of Agreement	6,500.00
Blue Cross of California	10/20/2021	I. Utilization Review, H. Licensing Standards	Letter of Agreement	5,000.00
Blue Cross of California	09/20/2021	E. Grievance and Appeals	Letter of Agreement	10,000.00
Blue Cross of California	09/08/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	08/19/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	07/16/2021	E. Grievance and Appeals, B. Claims, D. Financial Solvency and Audits	Letter of Agreement	17,500.00
Blue Cross of California	07/16/2021	K. Operating at Variance with the EOC	Letter of Agreement	5,000.00
Blue Cross of California	07/15/2021	W. Independent Medical Review	Letter of Agreement	5,000.00
Blue Cross of California	07/15/2021	K. Operating at Variance with the EOC	Letter of Agreement	15,000.00
Blue Cross of California	07/15/2021	K. Operating at Variance with the EOC	Letter of Agreement	35,000.00
Blue Cross of California	07/15/2021	K. Operating at Variance with the EOC, G. Basic Health Care Services, E. Grievance and Appeals	Letter of Agreement	15,000.00
Blue Cross of California	06/24/2021	W. Independent Medical Review	Letter of Agreement	70,000.00
Blue Cross of California	06/16/2021	B. Claims	Letter of Agreement	5,000.00
Blue Cross of California	06/14/2021	K. Operating at Variance with the EOC, B. Claims, D. Financial Solvency and Audits	Letter of Agreement	25,000.00
Blue Cross of California	06/14/2021	E. Grievance and Appeals	Letter of Agreement	7,000.00
Blue Cross of California	06/08/2021	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	1,377.00
Blue Cross of California	06/08/2021	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	222,425.00
Blue Cross of California	06/08/2021	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	1,377.00
Blue Cross of California	06/08/2021	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	689.00
Blue Cross of California	06/08/2021	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	689.00
Blue Cross of California	06/08/2021	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	689.00
Blue Cross of California	06/08/2021	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	1,377.00
Blue Cross of California	06/08/2021	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	1,377.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Employee Health Systems Medical Group, Inc.	05/14/2021	I. Utilization Review, BB. Quality Assurance, C. Delegation Oversight, H. Licensing Standards	Lift Cease and Desist Order	No fine issued
Blue Cross of California	03/22/2021	D. Financial Solvency and Audits, B. Claims, E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/22/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/22/2021	E. Grievance and Appeals	Letter of Agreement	6,000.00
Blue Cross of California	03/22/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/22/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/22/2021	E. Grievance and Appeals	Letter of Agreement	6,000.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,500.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,500.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals	Letter of Agreement	5,500.00
Blue Cross of California	03/12/2021	E. Grievance and Appeals, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	02/01/2021	K. Operating at Variance with the EOC, D. Financial Solvency and Audits, B. Claims	Letter of Agreement	5,000.00
Blue Cross of California	01/26/2021	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	7,000.00
Blue Cross of California	01/13/2021	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	5,000.00
Blue Cross of California	11/20/2020	K. Operating at Variance with the EOC	Letter of Agreement	7,500.00
Blue Cross of California	11/18/2020	B. Claims	Letter of Agreement	6,500.00
Blue Cross of California	11/18/2020	K. Operating at Variance with the EOC	Letter of Agreement	44,750.00
Blue Cross of California	11/18/2020	E. Grievance and Appeals, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	10/30/2020	E. Grievance and Appeals	Letter of Agreement	7,500.00
Blue Cross of California	10/15/2020	D. Financial Solvency and Audits, B. Claims, I. Utilization Review, H. Licensing Standards	Letter of Agreement	15,000.00
Blue Cross of California	09/23/2020	D. Financial Solvency and Audits, S. Provider Dispute Resolution	Letter of Agreement	2,000.00
Blue Cross of California	09/23/2020	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	3,000.00
Blue Cross of California	09/23/2020	S. Provider Dispute Resolution, D. Financial Solvency and Audits	Letter of Agreement	2,500.00
Blue Cross of California	09/23/2020	D. Financial Solvency and Audits, B. Claims	Letter of Agreement	5,000.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,300.00
Blue Cross of California	07/23/2020	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	1,200.00
Blue Cross of California	06/02/2020	J. Provider Networks, E. Grievance and Appeals	Letter of Agreement	7,500.00
Blue Cross of California	05/15/2020	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	15,000.00
Blue Cross of California	05/09/2020	B. Claims	Letter of Agreement	2,500.00
Blue Cross of California	04/11/2020	E. Grievance and Appeals	Letter of Agreement	7,500.00
Blue Cross of California	04/08/2020	K. Operating at Variance with the EOC	Letter of Agreement	5,000.00
Blue Cross of California	03/06/2020	B. Claims, D. Financial Solvency and Audits, K. Operating at Variance with the EOC	Letter of Agreement	17,500.00
Blue Cross of California	02/20/2020	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	01/24/2020	E. Grievance and Appeals	Letter of Agreement	5,000.00
Encompass Medical Group	01/06/2020	B. Claims, D. Financial Solvency and Audits	Letter of Agreement	10,000.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Employee Health Systems Medical Group, Inc.	12/17/2019	I. Utilization Review, BB. Quality Assurance, C. Delegation Oversight, H. Licensing Standards	Letter of Agreement	30,000.00
Blue Cross of California	11/21/2019	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	10,000.00
Blue Cross of California	11/04/2019	K. Operating at Variance with the EOC	Letter of Agreement	5,000.00
Blue Cross of California	10/23/2019	D. Financial Solvency and Audits, B. Claims	Letter of Agreement	7,500.00
Blue Cross of California	09/18/2019	R. Solicitor/Agent & Solicitor Firms, H. Licensing Standards	Letter of Agreement	5,000.00
Blue Cross of California	09/12/2019	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
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Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
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Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued

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Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	06/05/2019	E. Grievance and Appeals	Settlement Agreement	No fine issued
Blue Cross of California	05/20/2019	G. Basic Health Care Services, K. Operating at Variance with the EOC	Letter of Agreement	5,000.00
Blue Cross of California	04/23/2019	I. Utilization Review	Letter of Agreement	20,000.00
Blue Cross of California	04/23/2019	K. Operating at Variance with the EOC	Letter of Agreement	2,500.00
Blue Cross of California	04/23/2019	N. Timely Access Reporting, J. Provider Networks	Letter of Agreement	7,500.00
Blue Cross of California	03/25/2019	B. Claims, D. Financial Solvency and Audits	Letter of Agreement	7,500.00
San Benito Medical Associates, Inc.	02/07/2019	C. Delegation Oversight, D. Financial Solvency and Audits	Lift Cease and Desist Order	No fine issued
Verity Medical Foundation	01/31/2019	C. Delegation Oversight, D. Financial Solvency and Audits	Cease and Desist Order	No fine issued
San Benito Medical Associates, Inc.	01/31/2019	C. Delegation Oversight, D. Financial Solvency and Audits	Cease and Desist Order	No fine issued
Blue Cross of California	01/08/2019	H. Licensing Standards, G. Basic Health Care Services, K. Operating at Variance with the EOC	Letter of Agreement	100,000.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Blue Cross of California	01/08/2019	B. Claims, D. Financial Solvency and Audits	Letter of Agreement	5,000.00
Blue Cross of California	12/28/2018	M. Medical Surveys	Letter of Agreement	5,000.00
Pioneer Provider Network	12/13/2018	D. Financial Solvency and Audits, BB. Quality Assurance, C. Delegation Oversight	Cease and Desist Order	No fine issued
Blue Cross of California	11/30/2018	B. Claims, E. Grievance and Appeals	Letter of Agreement	10,000.00
Blue Cross of California	08/28/2018	W. Independent Medical Review	Judicial Order/Ruling	No fine issued
Blue Cross of California	08/28/2018	W. Independent Medical Review	Judicial Order/Ruling	No fine issued
Blue Cross of California	08/28/2018	W. Independent Medical Review	Judicial Order/Ruling	No fine issued
Blue Cross of California	08/28/2018	W. Independent Medical Review	Judicial Order/Ruling	50,000.00
Blue Cross of California	07/26/2018	X. Completion of Covered Services, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	07/26/2018	B. Claims	Letter of Agreement	5,000.00
Blue Cross of California	07/11/2018	R. Solicitor/Agent & Solicitor Firms, No Violation Category Assigned	Letter of Agreement	No fine issued
Blue Cross of California	07/11/2018	No Violation Category Assigned, R. Solicitor/Agent & Solicitor Firms	Letter of Agreement	No fine issued
Blue Cross of California	07/11/2018	R. Solicitor/Agent & Solicitor Firms, No Violation Category Assigned	Letter of Agreement	No fine issued
Blue Cross of California	07/11/2018	R. Solicitor/Agent & Solicitor Firms, No Violation Category Assigned	Letter of Agreement	70,000.00
Blue Cross of California	05/01/2018	B. Claims	Letter of Agreement	10,000.00
Blue Cross of California	04/09/2018	E. Grievance and Appeals, R. Solicitor/Agent & Solicitor Firms	Letter of Agreement	30,000.00
Blue Cross of California	04/09/2018	G. Basic Health Care Services, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	04/09/2018	D. Financial Solvency and Audits, E. Grievance and Appeals, B. Claims	Letter of Agreement	10,000.00
Blue Cross of California	03/23/2018	J. Provider Networks, H. Licensing Standards, N. Timely Access Reporting	Letter of Agreement	7,500.00
Blue Cross of California	03/23/2018	G. Basic Health Care Services, K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	20,000.00
Blue Cross of California	03/02/2018	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	10,000.00
Blue Cross of California	03/02/2018	E. Grievance and Appeals, K. Operating at Variance with the EOC	Letter of Agreement	No fine issued
Blue Cross of California	03/02/2018	E. Grievance and Appeals, K. Operating at Variance with the EOC	Letter of Agreement	No fine issued
Blue Cross of California	03/02/2018	E. Grievance and Appeals, K. Operating at Variance with the EOC	Letter of Agreement	No fine issued
Blue Cross of California	03/02/2018	K. Operating at Variance with the EOC, E. Grievance and Appeals	Letter of Agreement	10,000.00
Blue Cross of California	02/22/2018	K. Operating at Variance with the EOC	Letter of Agreement	5,000.00
Blue Cross of California	01/29/2018	E. Grievance and Appeals, I. Utilization Review, H. Licensing Standards	Letter of Agreement	12,000.00
Blue Cross of California	01/29/2018	E. Grievance and Appeals	Letter of Agreement	5,000.00
Blue Cross of California	01/29/2018	E. Grievance and Appeals	Letter of Agreement	8,000.00
Blue Cross of California	01/29/2018	H. Licensing Standards, I. Utilization Review	Letter of Agreement	5,000.00

Organization	Action Date	Violation Categories	Document Category	Fine Assessed ($)/Outcome*
Employee Health Systems Medical Group, Inc.	12/26/2017	I. Utilization Review, BB. Quality Assurance, C. Delegation Oversight, H. Licensing Standards	Cease and Desist Order	No fine issued
Blue Cross of California	12/08/2017	L. Personal Health Information Disclosure	Letter of Agreement	15,000.00
Blue Cross of California	11/29/2017	E. Grievance and Appeals	Letter of Agreement	8,000.00
Blue Cross of California	11/15/2017	E. Grievance and Appeals	Accusation	No fine issued
Blue Cross of California	10/13/2017	D. Financial Solvency and Audits, B. Claims	Letter of Agreement	7,500.00
Blue Cross of California	08/31/2017	H. Licensing Standards	Letter of Agreement	7,500.00
Blue Cross of California	08/03/2017	E. Grievance and Appeals	Letter of Agreement	7,500.00
Blue Cross of California	07/27/2017	H. Licensing Standards, I. Utilization Review, K. Operating at Variance with the EOC	Letter of Agreement	7,500.00
Blue Cross of California	07/20/2017	J. Provider Networks	Letter of Agreement	5,000.00
Blue Cross of California	07/20/2017	V. Improper Cancellation or Rescission of Coverage	Letter of Agreement	25,000.00
Blue Cross of California	07/20/2017	B. Claims, K. Operating at Variance with the EOC	Letter of Agreement	10,000.00
Blue Cross of California	06/22/2017	J. Provider Networks	Letter of Agreement	5,000.00

* If the DMHC identifies any system or systemic issues or deficiencies, the Blue Cross process is to take prompt action to remedy any such issue or deficiency.

[redacted]

[redacted]

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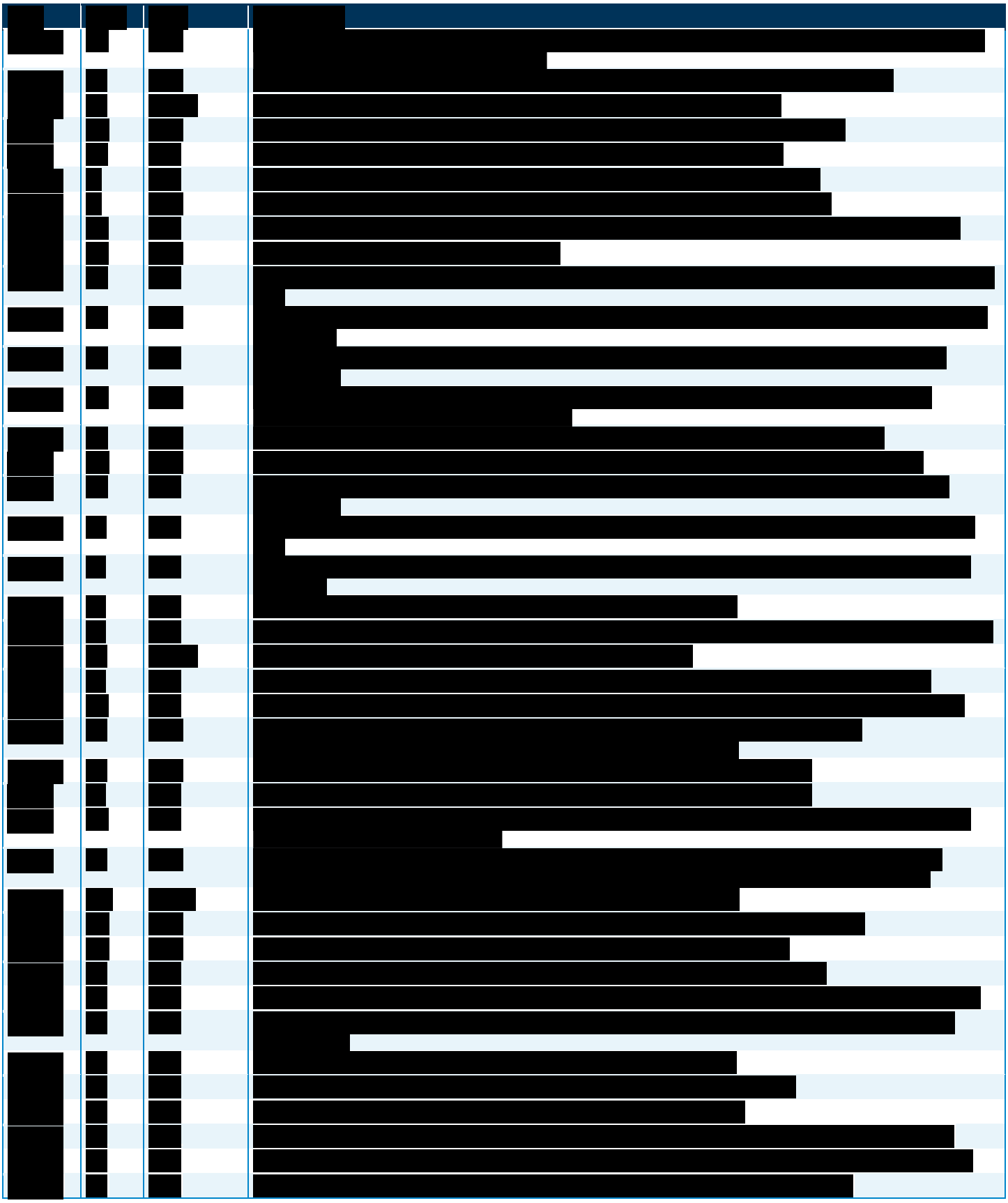
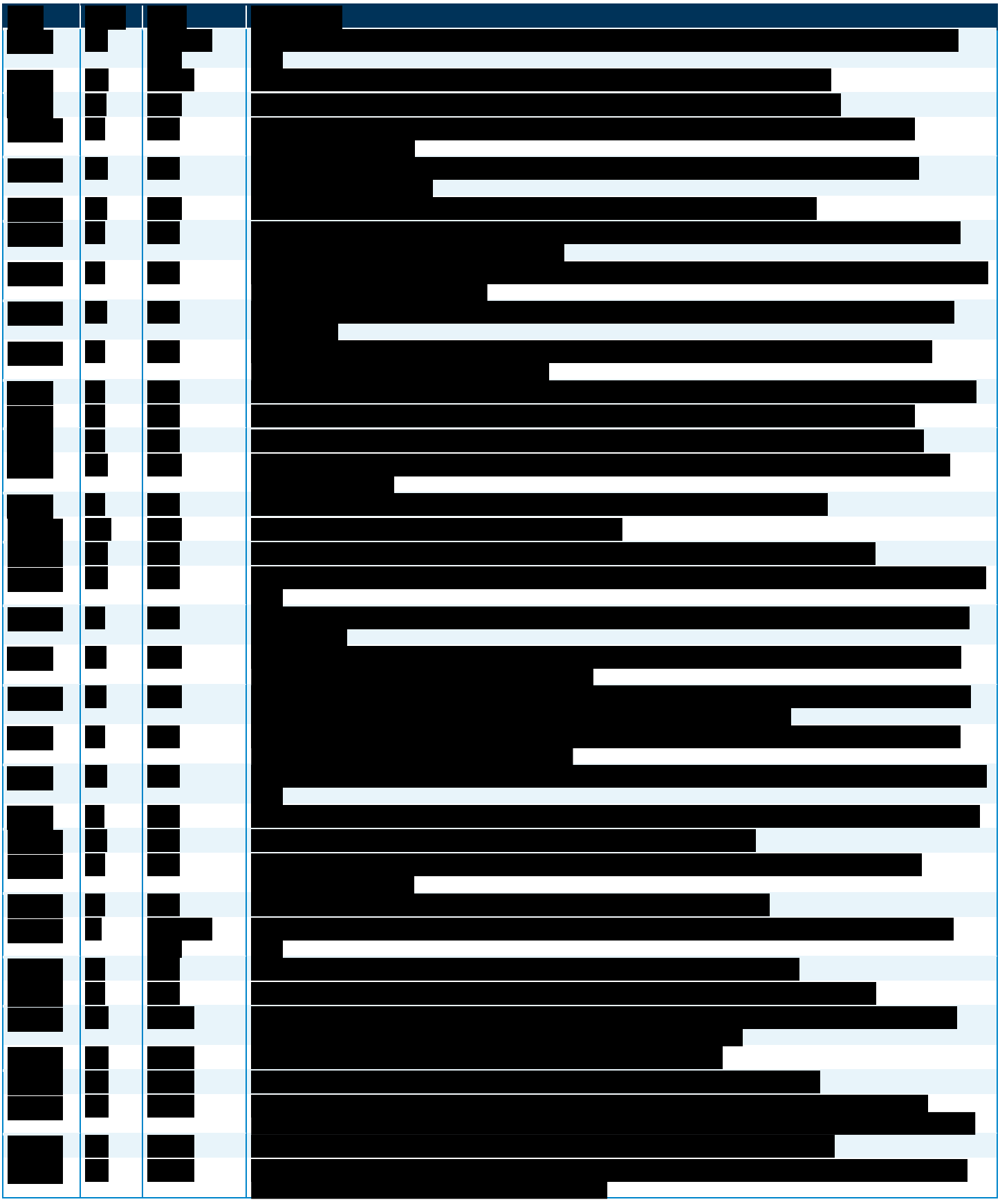
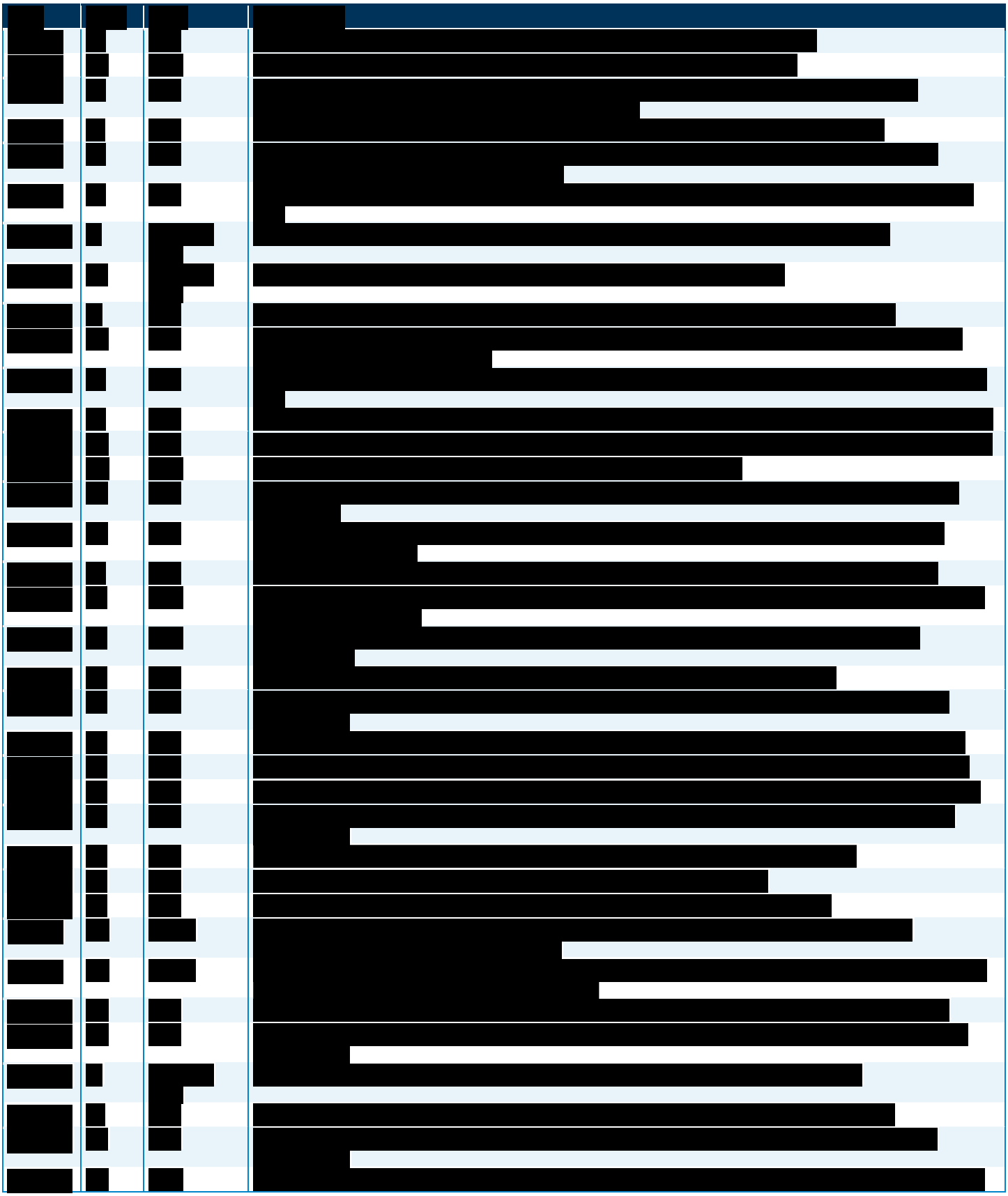
[redacted]







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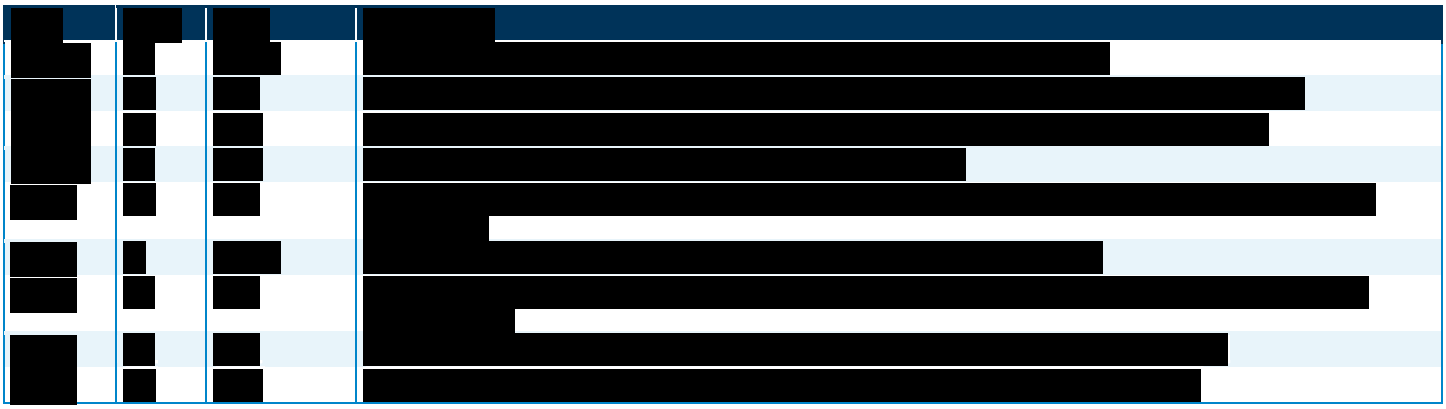


A.8

Corporate Experience Summary

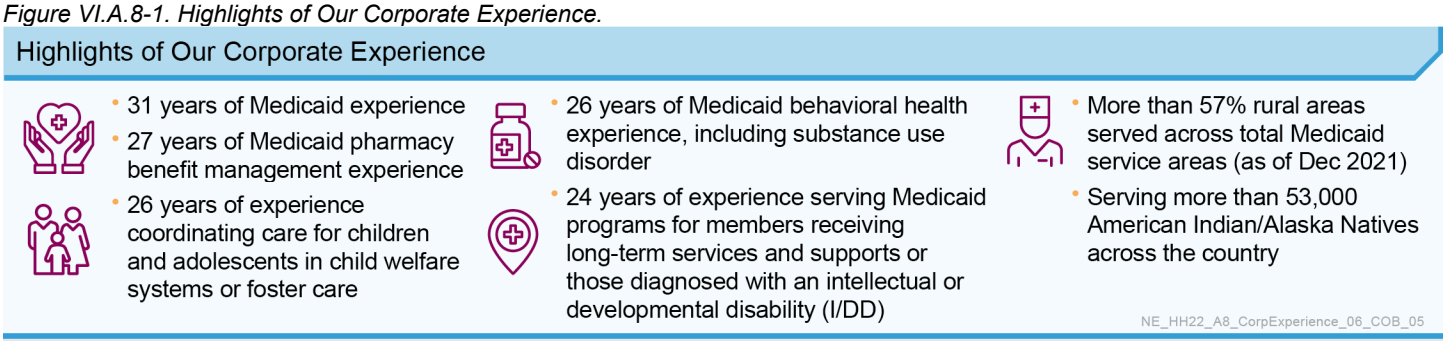
As an incumbent MCO, Healthy Blue has served Nebraskans since the beginning of Heritage Health. Throughout our tenure in the state, our local team has remained dedicated to making sure every member has access to the services and supports they need. From key leadership to front-line staff, most of our employees live and work right here in Nebraska and are accustomed to working collaboratively with the State as well as other MCOs, providers, and community organizations to achieve a healthier Nebraska.

To supplement our local footprint, Healthy Blue benefits from the experience and expertise of our national organization, providing proven best practices and innovative tools and solutions to health care's most complex problems and demonstrating our ability to deliver on contract requirements within the specified timeframes. Through health plan affiliates, our organization administers health benefit solutions to more than 118 million members through a broad portfolio of integrated health care plans, including more than 10.9 million Medicaid members in 26 markets.

Our affiliate health plans have been coordinating and providing care for Medicaid populations across the nation for more than 31 years. Some highlights of our corporate experience are provided in Figure VI.A.8-1. ***We benefit from their deep and varied knowledge, lessons learned, and best practices, including more than 270 successful implementations and readiness reviews.*** Covered services include physical health, behavioral health (BH), dental, vision, pharmacy, Non-Emergency Medical Transportation, and long-term services and supports, with coverage varying by market. Together, we have been a trusted health partner for decades, and currently serve:

- 8.7 million TANF members in 24 markets
- 425,000 CHIP members in 19 markets
- 117,000 children and adolescents in foster care and child welfare systems across 19 markets
- 302,000 members receiving LTSS across 11 markets
- 630,000 members covered under an Aged, Blind, and Disabled (ABD) plan in 21 markets
- 1.9 million members under Medicaid expansion coverage in 16 markets

Figure VI.A.8-1. Highlights of Our Corporate Experience.



Our national experience is a testament to our ability to build and maintain partnerships that deliver high-quality, cost-effective health care, underscored by consistently high levels of member and provider satisfaction. We also tap into the local experience and longevity of BCBSNE, a trusted health care partner in Nebraska for more than 80 years. BCBSNE is Nebraska's largest health insurance company and the only one headquartered in the state. As Healthy Blue, we have direct access to the operational and fiscal support, experience, and best practices of our national organization and BCBSNE. Whether provided by our local health plan personnel or the leveraged expertise, personnel, technology, and experience of our national organization, our objectives are always set with the State's expectations and our members' health outcomes in mind. Table VI.A.8-1 provides a summary matrix listing our affiliates serving Medicaid members in Nebraska and 25 other states, many of which hold similarities in size, geography, scope, populations, and complexity.

Table VI.A.8-1. Healthy Blue and Our Affiliates' Experience Spans 26 Markets Serving More Than 10 Million Members.

State	TANF	CHIP	ABD	Dual-eligible Members	Foster Care/Child Welfare	Medicaid Expansion	Total Members	Years Served
Nebraska	✓	✓	✓	✓	✓	✓	**113,466**	**5**
Arkansas				✓	✓		16,880	3
California	✓		✓	✓		✓	1,403,019	31
Colorado					✓		408,814	3
Florida	✓	✓	✓	✓	✓		741,903	19
Georgia	✓	✓			✓		589,402	16
Indiana	✓	✓	✓	✓	✓	✓	730,920	15
Iowa	✓	✓	✓	✓	✓	✓	449,762	6
Kentucky	✓	✓	✓	✓	✓	✓	171,536	8
Louisiana	✓	✓	✓		✓	✓	361,443	10
Maryland	✓	✓	✓		✓	✓	323,795	22
Minnesota	✓		✓	✓	✓	✓	349,639	3

State	TANF	CHIP	ABD	Dual-eligible Members	Foster Care/Child Welfare	Medicaid Expansion	Total Members	Years Served
Missouri	✓	✓			✓	✓	356,396	24
Nevada	✓	✓		✓	✓	✓	195,101	13
New Jersey	✓	✓	✓	✓	✓	✓	245,423	26
New York	✓	✓	✓		✓	✓	560,715	30
North Carolina	✓	✓	✓				449,489	1
Ohio	✓						256,302	<1
Puerto Rico	✓	✓	✓				317,720	7
South Carolina	✓		✓		✓		183,657	14
Tennessee	✓	✓	✓	✓			507,860	15
Texas	✓	✓	✓	✓	✓		1,026,841	25
Virginia	✓	✓	✓	✓	✓	✓	549,373	25
Washington	✓	✓	✓			✓	257,180	9
West Virginia	✓	✓	✓			✓	198,794	19
Wisconsin	✓		✓	✓	✓		154,230	16

Narrative Descriptions of Similar Experience

Tables VI.A.8-2, VI.A.8-3, and VI.A.8-4 provide descriptions of our current experience as an incumbent, serving Heritage Health members since 2017, along with two other examples similar in size and scope.

Table VI.A.8-2. Healthy Blue Brings Substantial Project Experience Serving Nebraska and Beyond (Through Our Affiliates).

Example 1: Nebraska	Narrative Description
a. Overview and Description of Similarities	Since 2017, Healthy Blue has served Nebraska Heritage Health administering the delivery of physical health, behavioral health, pharmacy, vision, and transportation services to members across the state.
i. Time Period of the Project	Five years s
ii. Scheduled and Actual Completion Date	Original start: January 1, 2017 (acquisition by Anthem, Inc. effective January 23, 2020) Current contract original term: January 1, 2017–December 31, 2021 Extension option(s) exercised: January 1, 2020–December 31, 2022, March 24, 2022-December 21, 2023
iii. Bidder's Responsibilities	Our mission and goals complement and support DHHS' priorities for Heritage Health. As an MCO, we are responsible for administering Medicaid covered services, which include physical health, behavioral health, and pharmacy. Along with administering covered services, we address social determinants of health to make sure members are receiving the most appropriate care and supports to address their whole health needs. We also provide population health and care management strategies that help promote healthier communities and improve outcomes for our members. We work collaboratively with the State as well as other MCOs, providers, and community organizations to accomplish the goals DHHS established for an integrated managed care program: ▪ Improved health outcomes ▪ Enhanced member satisfaction ▪ Enhanced coordination of care and quality of care ▪ Reduced rate of costly and avoidable care ▪ Improved fiscal accountability We deliver on our commitments by: promoting quality and advancing data-driven, evidence-based practices; delivering holistic, high-value care that addresses physical, behavioral, and social needs; supporting providers by simplifying processes and incentivizing value; bridging community resources to focus on the well-being of whole communities; maximizing the health of our members by tackling the root causes of health disparities; and fostering an organizational culture modeled on continuous process improvement, agility, and performance. Healthy Blue's diverse staff champion our mission and goals every day, and make sure we fulfill our responsibilities to those we serve under the Heritage Health contract. We listen, learn, and develop solutions to meet evolving member needs, bolstering our providers and the health care infrastructure to meet those needs across the state. Further, we routinely report on our performance to the State via metrics that measure member and provider engagement, network adequacy, claims adjudication, care

Example 1: Nebraska	Narrative Description
	management, quality of care, utilization management, and financials. For us, experience means having proven results, and we are proud of the continued improvements and incremental gains we see throughout our program — from effectively processing provider claims to assure timely payment to improving HEDIS® rates, we know outcomes matter. The following represent a small sample of our results and measurable outcomes we have achieved in serving Nebraska: ▪ Since 2019, we have steadily improved more than 15 CAHPS® measures by more than 5% ▪ Earned a current CAHPS rating of 4 stars ▪ Achieved more than 10 adult CAHPS measures at the 90th percentile ▪ Steadily improved more than 20 HEDIS measures from physical and behavioral health over 5% each ▪ Improved our cervical cancer screening rates from the 25th percentile to the 90th percentile between 2018 and 2021 ▪ Decreased readmission rates from 10.51 to 7.07 (for adults who had an inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge)
iv. Customer Name and Contact Info	Kevin Bagley, Medicaid Director Nebraska Department of Health and Human Services 301 Centennial Mall South Lincoln, Nebraska 68509 Email: Kevin.Bagley@nebraska.gov Phone: (402) 471-2735
v. and vi. Work Performed as Prime Contractor	The exact value of the contract at execution is typically not known, and may depend on annually adjusted capitation rates, and other factors such as fluctuations in member enrollment (for example, MCOs have experienced increased member enrollment and eligibility during the pandemic). The estimated value of the contract since 2020 is approximately $911 million.
vii. Subcontractors	Healthy Blue is the prime contractor. We leverage our national organization for administrative/support services, including the following for delegated services: Avesis – Vision services, Intelliride – NEMT services, IngenioRx, Inc. – Pharmacy services. Dental is not currently included in the Healthy Blue contract. (For the new contract, our vision subcontractor will be Superior Vision and our NEMT subcontractor will change to ModivCare).

Table VI.A.8-3. Our Missouri Affiliate Brings Similar and Extensive Experience Serving Members.

Example 2: Missouri	Narrative Description
a. Overview and Description of Similarities	For 23 years, our affiliate in Missouri (Missouri Care, Inc.) has served the state's MO HealthNet program, administering the delivery of physical health, behavioral health, dental, vision, and transportation services for more than 340,000 Medicaid members.
i. Time Period of the Project	23 years
ii. Scheduled and Actual Completion Date	Original start: 1999 (acquisition by Anthem, Inc. effective January 23, 2020) Current contract original term: May 1, 2017–June 30, 2018 Extension option(s) exercised: July 1, 2018–June 30, 2022 Missouri Care was awarded a new contract on May 20, 2022 following a competitive procurement. The new contract date is July 1, 2022 for a one-year term, followed by four one-year renewal options.
iii. Bidder's Responsibilities	Missouri Care (d/b/a Healthy Blue) makes sure members have access to the full range of services and supports they need to live a healthy life. They prioritize providing member-centered solutions and tools that promote individual choice and access, customized to fit members' needs based not only on their geographic location, but also on their individual preferences regarding setting of care, management and direction of services, and provider and caregiver selection. They support a fully integrated and accountable system of care by promoting family-centered, community-based, coordinated care that addresses physical, behavioral, pharmacy, and social determinants of health needs concurrently, with stakeholders across Missouri. In connecting members to the services and supports they need, Healthy Blue provides: ▪ A comprehensive Health Equity plan to change the trajectory of health disparities and reimagine a more equitable health care system by prioritizing prevention and wellness ▪ Bidirectional data integration that enables all providers to take advantage of our analytics and data, especially small, rural practices, and improve health care delivery through enhanced data sharing and effective administrative processes

Example 2: Missouri	Narrative Description
	▪ Integrated social and economic value-added services that promote self-sufficiency, support self-managed care, promote cost savings, and drive improved health outcomes ▪ Holistic, person-centered approach supports informed choice for all members, regardless of the complexity of their needs, and service delivery in the most integrated settings of their choice ▪ A comprehensive provider network of more than 16,000 contracted providers, including 4,427 PCPs, 10,674 specialists, 160 hospitals, and 224 facilities with a full complement of telehealth service The plan follows the Missouri Model, a developmental framework for trauma-informed care that addresses the process of an organization moving along a continuum from trauma-aware to trauma-informed. The Missouri Model is guided by five key principles: safety, trustworthiness, choice, collaboration, and empowerment. It identifies key tasks for organizations as they move toward a trauma-informed approach from trauma-aware to trauma-informed. The following represent a small sample of our results and measurable outcomes achieved in serving Missouri: ▪ Our Missouri affiliate had the highest HEDIS rates for dental measures in Missouri for the last three years. In addition, our dedicated quality improvement focus contributed to the following increase in HEDIS measures from 2017 to 2020: Childhood immunizations Combo 10 increased by 35%, postpartum care by 36%, asthma medication ratio by 35% ▪ Surpassed NCQA's 75th percentile of performance for 19 HEDIS measures in 2020 ▪ Tied for highest managed care quality rating with 50 HEDIS measures scored at or above 50th percentile
iv. Customer Name and Contact Info	[redacted]
v. and vi. Work Performed as Prime Contractor	Missouri Care is the prime contractor. The exact value of the contract at execution is typically not known, and may depend on annually adjusted capitation rates, and other factors such as fluctuations in member enrollment (for example, MCOs have experienced increased member enrollment and eligibility during the pandemic). The estimated value of the contract since 2020 is approximately $1.8 billion.
vii. Subcontractors	Missouri Care is the primary contractor and leverages our parent company for administrative/support services and includes (but is not limited to) the following for delegated services: March Vision – Vision services, DentaQuest – Dental services, MTM – Non-Emergency Medical Transportation services.

Table VI.A.8-4. Our Virginia Affiliate Brings Similar and Extensive Experience Serving Members.

Example 3: Virginia	Narrative Description
a. Overview and Description of Similarities	Our affiliate in Virginia (HealthKeepers, Inc.) has administered the delivery of services to members statewide, including physical health, behavioral health, LTSS, pharmacy, dental, and vision. HealthKeepers has served Medicaid members through the state's Medallion program for the last 25 years and recently began serving its LTSS program (Commonwealth Coordinated Care Plus) over the last four years.
i. Time Period of the Project	Commonwealth Coordinated Care Plus: Four years Medallion: 25 years
ii. Scheduled and Actual Completion Date	Commonwealth Coordinated Care Plus: Original start: July 1, 2017 Current contract: July 1, 2020–June 30, 2022 Medallion: Original start: July 1, 1996 Current contract original term: July 1, 2019–June 30, 2020 Extension option(s)exercised: July 1, 2020–June 30, 2022
iii. Bidder's Responsibilities	Anthem HealthKeepers is the largest Medicaid health plan in the state, serving more than half a million members through our Medallion Medicaid and Commonwealth Coordinated Care Plus (for seniors and individuals with Intellectual and Developmental Disabilities). With more than two decades of experience in Virginia, Anthem HealthKeepers administers the covered services and benefits for members across the state, including physical health, BH, pharmacy, dental, vision, transportation, and long-term services and supports. Anthem HealthKeepers makes sure members have access to the full range of services and supports they need to live a healthy life. The plan

Example 3: Virginia	Narrative Description
	prioritizes providing member-centered solutions and tools that promote individual choice and access, customized to fit members' needs based not only on their geographic location, but also on their individual preferences regarding setting of care, management and direction of services, and provider and caregiver selection. The plan supports a fully integrated and accountable system of care by promoting family-centered, community-based, coordinated care that addresses physical, behavioral, pharmacy, and social determinants of health needs concurrently, with stakeholders across Virginia. Throughout the years, the plan has achieved high performance markets, including a 3.5 STAR rating. Other results and measurable outcomes for Medallion include: ▪ Implemented behavioral health homes with multiple Community Service Boards. In the first two years of the program, achieved: ▪ Reduction in emergency room use an average of 24.8% ▪ Reduction in behavioral health admissions by 18% and physical health admissions by 31% ▪ More than 70% of providers participating in a quality incentive plan and shared savings agreements earned payouts for their 2020 performance For the Coordinated Care Plus Plan, Anthem HealthKeepers earned NCQA's LTSS Distinction (through 2024). Since the program's launch, the number of members participating in consumer-directed services has increased more than tenfold, helping enable older adults and those living with disabilities to stay in their own homes or a family member's home in the community.
iv. Customer Name and Contact Info	[redacted]
v. and vi. Work Performed as Prime Contractor	HealthKeepers is the prime contractor. The exact value of the contract at execution is typically not known, and may depend on annually adjusted capitation rates, and other factors such as fluctuations in member enrollment (for example, MCOs have experienced increased member enrollment and eligibility during the pandemic). For Coordinated Care Plus, the estimated value of the contract since 2017 is approximately $6.4 billion. For Medallion, the estimated value of the contract since 2005 is $9.5 billion.
vii. Subcontractors	Anthem HealthKeepers is the prime contractor. Our Virginia affiliate leverages our national organization for administrative/support services and includes (but is not limited to) the following for delegated services: EyeMed – Vision services, Access2Care – Non-Emergency Medical Transportation services, and IngenioRx, Inc. – Pharmacy services.

Customer References

Healthy Blue provides three references in Table VI.A.8-5. The referenced clients are knowledgeable of Healthy Blue and our affiliates' performance in providing services similar to those sought in this RFP, through other Medicaid programs.

Table VI.A.8-5. Affiliate's Client References.

Client
[redacted]
[redacted]

Client

[redacted]

Letters of Support

Healthy Blue has received more than 50 Letters of Support from Nebraska stakeholders, providers, and organizations such as Boy Scouts, Catholic Charities, and Partnership4Kids. We are continuing to build lasting relationships with stakeholders across the state to improve the health and lives of that will benefit our members. We provide a sampling of those Letters of Support received in Attachment VI.A.8-1.

A.9

Healthy Blue's Approach to Management of the Project

Healthy Blue built its organizational structure on local health care solutions while leveraging the experience of our Medicaid affiliates in 25 other Medicaid markets as well as the vast network and national resources of our parent companies, Elevance Health, Inc. (previously known as Anthem, Inc.), a leading health care company in the country, and Blue Cross and Blue Shield of Nebraska (BCBSNE), a trusted name in the state for more than 80 years and the only health care insurance company headquartered in Nebraska. Through our local management approach, we use multi-functional strategies along with tailored tools, resources, and processes to produce operational efficiencies and meet the needs of our members, providers, and the State.

More than 80% of our staff who support our Nebraska operations live and work right here in the state. We recognize that Nebraska is more than just the urban areas around Lincoln and Omaha, and we have built our teams to mirror the communities we serve by bringing knowledge of local resources, nuances, culture, language, and norms. ***Our locally based staff work diligently to establish and deliver meaningful programs and resources — in every county, every region, for every Healthy Blue member we serve. We are more than just a health plan: we are neighbors serving neighbors in every corner of the state.***

We know that delivering an integrated, patient-centered, outcomes-focused program depends on the people who run our health plan day after day. Whether it is delivering direct member and provider support, creating innovative solutions, reviewing and analyzing data, or negotiating cost savings opportunities, our people bring the mission, vision, and outcomes to life. Our management approach centers on key leaders who are steeped in Nebraska experience that spans decades. ***Our leadership team brings more than 250 years of collective tenure working in health care and more than 100 of those years collectively spent serving Nebraska's Medicaid program.*** This leadership team guides every functional area to meet the needs of members and improve health outcomes, access to care, and members' and providers' overall experience.

Corporate Name Change

Effective June 28, 2022, our parent company Anthem, Inc. changed its name to Elevance Health to reflect the next important chapter in our journey, as it better reflects our business and the company we are today. Elevance Health is the combination of elevate + advance to convey our commitment to innovation and our pursuit of moving health forward — elevating the importance of whole health and advancing health beyond health care.

A Management Approach That Champions People and Their Communities

Our management approach centers on accountability, leadership engagement with regular and transparent communication, and a philosophy of continuous improvement. Healthy Blue operates under our ***CEO, Dr. Robert Rhodes***, and is supported by our team of key leadership, who has full authority over service delivery and is directly accountable to the State, members, providers, and stakeholders. Our leadership oversees, monitors, supervises, and enforces contract compliance, and continuously promotes a two-way street of frequent, open, and effective communication across all employees and functional areas. Our management structure assures full accountability from Nebraska leadership, while facilitating best practices sharing, innovations, support, and lessons learned from our parent organizations and affiliates. Dr. Rhodes works closely with our leadership team, including our Chief Financial Officer and Chief Operating Officer, to make sure Healthy Blue operations run seamlessly and effectively in providing services and supports consistent with member needs and in accordance with the contract.

We built a comprehensive framework to oversee and coordinate our operations based on a strong culture of collaboration. As a servant leader, Dr. Rhodes focuses on the growth and well-being of people and the communities to which they belong, championing the development of all employees so that we can provide the best possible services.

Dr. Rhodes holds monthly meetings as part of our Ambassador program, established as a formal communication method to draw on varying perspectives across our organization and facilitate dialogue among staff on real-time issues. Through Ambassador meetings, Dr. Rhodes and our leadership team provide all our employees an avenue to provide meaningful input and receive relevant updates about matters of immediate importance to our business. The result: greater transparency in our business operations, broad and valuable insights from our highly skilled staff, and better engagement across all levels of our organization.

As our CEO, Dr. Rhodes also holds monthly all-staff meetings to share information about organizational initiatives, leverage knowledge, build strength across the leadership team, discuss opportunities, and celebrate successes. These collaborative meetings allow leaders across our health plan to share details on any emerging risks and issues, discuss potential resolution efforts, and share best practices and innovations that could be replicated by others in their service delivery.

Dr. Rhodes meets weekly with other senior leaders to discuss strategic and tactical initiatives and priorities, including program and contract management, operations, and compliance. He also holds monthly meetings with our Chief Financial Officer and Finance team to review internal financial reports. As a member of the Executive Leadership team, Dr. Rhodes frequently communicates with our key leadership to review strategy, business and operational performance, quality key metrics, and financial results.

CALLED TO CARE
Robert Rhodes, MD, Chief Executive Officer

I have lived in Nebraska the last 28 years, and I have worked in Medicaid for 3 years. I am passionate about helping to lead and work with a dedicated team that has great heart for our members. When I was CMO, I took pride in pushing past barriers to help members get the care they needed at the right time and place. One example was getting a young member urgent transportation into a non-participating ophthalmology specialist the next day to help save their vision. Later, we worked to get the provider into our network- so that was a great feeling of a team helping on several levels. Additionally, I am the Founder of Clinic with a Heart, a free health care clinic in Lincoln that serves the homeless, under-insured and uninsured. In that role, I have seen the effects of how social determinants like food insecurity and financial stress can determine someone's health. I want to lead with a servant heart to make a difference for all of those that are more vulnerable.

CALLED TO CARE: As a practicing Family Physician in Nebraska for 25 years, I knew Medicaid patients were a special group. Their life stories were amazing and many motivated me or gave me pause to understand ALL that they had endured or were enduring. Sometimes they needed just a little more time, someone to listen and to show them someone cared. I remember that is who I work to help now on a wider scale.

NE_HH22_RobertRhodes_MW_03

Operational Excellence Committee

As part of our management approach and to demonstrate our commitment to performance and compliance in key functional operations, we launched our ***Operational Excellence*** initiative in the second quarter of 2022. We remain steadfast in our long-term commitment to operational stability and excellence and to being an accountable and innovative MCO that supports the expectations of MLTC, along with the evolving needs of Heritage Health members and providers. Led by our ***Chief Operating Officer, Heather Leschinsky***, our new dedicated ***Operational Excellence team*** and ***Operational Excellence Committee*** will continuously raise the bar on our performance.

The Operational Excellence team monitors our processes to identify improvements and enhancements ahead of challenges. We leverage the latest process design and technology innovations to increase operational accuracy, through integrated, health plan-wide support. Our Operational Excellence team includes:

- **Claims Manager.** An expert in reimbursement methodology and system configuration to research and confirm configuration is correct and claims are paid appropriately. The Claims Manager also verifies that State-required configuration changes are implemented appropriately and any errors detected are corrected expeditiously, and confirms the configuration is tested and re-tested until proven accurate.
- **Provider Reimbursement Specialist.** A reimbursement and provider data expert, dedicated to provider-centric operational issues, working together with our field-based Provider Services team to answer provider questions and see any issue through to resolution in a timely manner.
- **Claims Reimbursement Specialist.** A claims coding and reimbursement expert to validate system changes and quickly address claims payment issues according to State, national, and industry standards. This specialist will also partner with the State to determine the best path forward regarding reimbursement changes.

The ***Operational Excellence Committee*** assures governance and monitoring to deliver short- and long-term solutions and includes members representing all areas of the health plan and national support services. This committee is charged with rapid responsiveness to member and provider issues, proactive approach to monitoring trends, improved transparency and communication with State partners, improved transparency and communication with providers, subcontractor oversight, and an integrated clinical relationship. The Operational Excellence Committee reports to the health plan Executive Leadership, and ultimately, our CEO, Dr. Rhodes.

Key Leadership: Areas They Oversee and Their Primary Work

Healthy Blue has a strong, established team of key staff (Table VI.A.9-1) who are accountable for fulfilling all contract requirements. We adhere to all requirements outlined in the RFP, Section V.D.2, Key Staff Positions. Next, we detail our key leadership and the areas they oversee, including their primary work and role in operational activities, individuals with whom they interface, and reporting relationships.

Table VI.A.9-1. Healthy Blue's Qualified Professionals Who Serve Nebraska.

Key Staff Title	Name
Chief Executive Officer	Robert Rhodes, MD, FAAFP
Chief Medical Officer	Debra Esser, MD
Dental Director	Holly Randone, DDS
Behavioral Health Clinical Director	Martin Wetzel, MD, CCHP
Behavioral Health Manager	Shannon Calabrese, LIMHP, LADC
Chief Operating Officer	Heather Leschinsky
Chief Financial Officer	James Cecil, MBA
Program Integrity Officer	Jennifer Bohnhoff, CCP
Grievance System Manager	Julie Godbout, MBA
Contract Compliance Officer	Christine Cole
Quality Management (QM) Coordinator	Janet Endorf-Olson, RN, CPHQ

Key Staff Title	Name
Performance and Quality Improvement Coordinator	Brittany Kuhns
Maternal Child Health/EPSDT Coordinator	Kaitlyn Dierks, BSN, RN
Medical Management Coordinator	Tami DeBonis, BSN, RN
Provider Services Manager	Jamie Ferguson, MHA
Member Services Manager	Jodi Payne
Claims Administrator	Leslie Langslow
Provider Claims Educator	Theresa Ellis
Case Management Administrator	Tamara Mostek, BSN, RN
Information Management and Systems Director/Business Continuity Planning and Emergency Coordinator	John Glenn, MCS
Encounter Data Quality Coordinator	Mona Ahmed, MCS
Tribal Network Liaison	Gelisha Jeffers
Pharmacy Director	Shannon Nelson, PharmD
Dental Management Coordinator	Marc Couch, MBA

Plan Administration

Our administration team includes key staff who oversee operations, finance, legal, human resources, and compliance functional areas to assure we are meeting all contract requirements. As our CEO, Dr. Rhodes has full and final responsibility for contract compliance. With more than 20 years as a Nebraska-licensed physician and former president of the Nebraska Medical Association, Dr. Rhodes, a board-certified family physician who has previously held numerous physician executive leadership roles, has served as our Chief Medical Officer and was recently appointed CEO in 2022. Earlier in his career, Dr. Rhodes founded the faith-based nonprofit, Clinic with a Heart, which provides free urgent short-term medical, chiropractic, physical therapy, and dental care to uninsured and underinsured residents who reside in the Lincoln area. In 2019, he received the COPIC Humanitarian Award, which honors a physician for their contribution to the community. All of our key staff ultimately report to Dr. Rhodes.

Our ***Chief Operating Officer (COO), Heather Leschinsky***, manages day-to-day operations across our departments to make sure that we continue to meet contract requirements and drive the best possible performance and support for members, providers, and the State. The COO stays in daily contact and works closely with our CEO and CFO to create operations strategies, programs, and policies to maintain our reputation as a trusted partner in the state. As the COO, Heather will serve as the primary contact with the State for all MCO operational issues. She brings more than 20 years of Medicaid experience, including 10 years in senior leadership roles. Heather previously worked for DHHS in leadership positions, such as the Chief Administrator for Medicaid Home- and Community-Based Services Project Management and Initiatives. Heather earned her bachelor's degree from the University of Nebraska at Lincoln and has devoted her career to serving Nebraskans.

Our locally based ***Chief Financial Officer, James Cecil***, manages the budgeting, forecasting, auditing, and financial reporting functions of our health plan. He develops analytical tools, models, and reports; monitors monthly claims production and service utilization; and administers a risk management program. James brings more than 20 years of experience in finance and seven years of experience in Medicaid managed care, health plan finance, and operations. In his role, James identifies and drives opportunities for savings with health plan leadership and monitors the assumptions and issues in the rate methodology. Accounting, data analytics, and actuarial functions are backed by national support services, with local oversight and management from James to assure contract compliance.

Whole Person Health

Healthy Blue's programs have been fully integrated and patient-centered, holistically addressing physical health, behavioral health, social services, and community supports for members since we began serving Nebraska. Our care management model combines physical and behavioral health Care Management teams, so that we can identify and address members' total health needs and goals across the spectrum of care and services. Care Management teams report to clinical leadership including the Chief Medical Officer and BH Clinical Director. Our team includes a variety of clinical and non-clinical support staff, all of whom are committed to improving the health of Nebraskans while addressing health equity, disparities, and building resilient communities.

To drive whole person health, we have strategically aligned the team to report to our ***Chief Medical Officer (CMO), Dr. Debra Esser***, and ***Behavioral Health Clinical Director, Dr. Martin Wetzel***. With more than 35 years of clinical and leadership experience, Dr. Esser is a Nebraska-licensed, board-certified family physician who has served in multiple senior-level management roles. Before taking on the CMO role, Dr. Esser was the Vice President of Medical Policy and Quality Management Director for BCBSNE. She earned her medical degree from the University of Nebraska College of Medicine and has spent her career serving Nebraskans. She was recently Chair of the Metro Omaha Medical Society and has served on the Boards of Live Well Omaha and Hope Medical. In her role as CMO, Dr. Esser drives all our major clinical, utilization management, and quality management initiatives. Engaging with our provider network, Dr. Esser also acts as our medical professional interface with providers, consulting as needed on policy and service authorization requests. Dr. Esser is supported by our Behavioral Health Director, Dr. Martin Wetzel, Case Management Administrator, Tamara Mostek, and our Behavioral Health Manager, Shannon Calabrese.

As our Behavioral Health Clinical Director, Dr. Wetzel provides guidance and clinical operations on our behavioral health programs, including substance use disorder treatment. With more than 30 years of experience, Dr. Wetzel is a Nebraska-licensed, board-certified psychiatrist who is also an associate professor of psychiatry at the University of Nebraska Medical Center. Dr. Wetzel earned his

medical degree from the University of Nebraska Medical Center and has devoted his career to serving Nebraskans. Working in close conjunction with Dr. Esser and our entire clinical leadership team, Dr. Wetzel helps ensure the delivery of fully integrated services across the spectrum of care.

In addition, pharmacy is an important component of our integrated approach. Our pharmacy program is backed by the resources and expertise of our affiliate Pharmacy Benefits Manager, IngenioRx (which facilitates our ability to integrate medical and pharmacy benefits more effectively). Our dedicated ***Pharmacy Director, Shannon Nelson, PharmD***, has overseen all aspects of pharmacy since 2016, working closely with clinical teams and leadership to make sure pharmacy services meets all applicable federal and State requirements. Our fully integrated pharmacy program supports members' total health needs through joint clinical meetings and committees along with interdisciplinary teams that use shared data and reporting to fully coordinate a member's care.

Our whole person health team includes our Care Management team of licensed clinicians (Registered Nurses, Licensed Mental Health Professionals, Licensed Clinical Social Workers) and non-clinical personnel as well as our Peer Support Specialist, Outreach Care Specialists, and Community Health Workers.

Health Equity Director. Healthy Blue's population health approach is integral to whole person health and to improving the health of Nebraskans. Support for population health starts with our CEO, Dr. Rhodes, who makes sure that all Healthy Blue operations, programs, and strategic partnerships align with our priorities and drive targeted outcomes. Throughout the past year, we have watched how a global pandemic has affected both physical and mental health. To drive whole person health, we have strategically aligned our care team to report to our Chief Medical Officer, while also establishing a new Health Equity Director position to help develop and drive health equity priorities across the organization. Our ***Health Equity Director, Tiffany White-Welchen, LIMHP***, acts as a health equity champion, leading community-based initiatives and strategies so that members have equitable care to achieve their health and wellness goals. Tiffany oversees our SDOH team, including our Housing Specialist, Employment Specialist, and others, to make sure members are connected to the social supports they need to be healthy.

Whole Health Director. Our new Whole Health Director will be a public health expert that will serve as the integrator across our functional domains to make sure that we take a culturally competent approach as we deploy programs, engage stakeholders, review data and outcomes, make necessary program changes and adjustments, and support the ongoing evaluation and acceleration of Healthy Blue's population health goals and objectives. Healthy Blue's new Whole Health Director will establish, inform, monitor, and execute our integrated whole community health strategy focusing on our five population health pillars: maternal child, Behavioral Health, rural health, vulnerable populations, chronic disease and prevention, by championing integration and articulating the goals and value of our comprehensive whole health model across our team. They will employ and implement core concepts of whole health improvement such as social determinants of health, health services research, epidemiology, and statistics to guide our strategic planning and will be responsible for building, preserving, and prioritizing collaborative, sustainable relationships with Nebraska's public health, social services, local governmental agencies, and community-based organizations. Our Whole Health Director will also assess population social needs screening tools, utilize risk modeling, and community needs assessments to leverage relevant to better understand Nebraska's Medicaid population served and translate that data into actionable evidence to inform strategic planning, policy, and partnership.

Quality Management

Our QM program structure supports a comprehensive and holistic approach using a continuous quality improvement philosophy that reinforces clear accountability. The program systematically monitors specific measures and evaluates the quality, safety, and appropriateness of both physical and behavioral health care so that we can act on opportunities to improve care and services. QM is an essential part of how Healthy Blue achieves the State's goals and objectives and meets the needs of members, providers, and community partners. Our QM Coordinator reports to our CEO.

Our Nebraska-based ***QM Coordinator, Janet Endorf-Olson, RN, CPHQ***, manages and oversees QI/QM activities and keeps our goals on target. A licensed Registered Nurse, Janet has more than 20 years of clinical quality management experience as well as core skills in patient safety, compliance, performance improvement, care coordination, and more.

All senior leadership support a culture of continuous quality improvement and are members of the Quality Assessment and Program Improvement Committee (QAPIC). The QAPIC includes our CEO, CMO, and QM Coordinator along with a newly created Health Equity Director position, our Whole Health Director and leaders from Population Health, BH Services, and Provider Solutions. Dr. Esser and Janet Endorf-Olson oversee the QAPIC, which provides multi-disciplinary and cross-functional direction and oversight of all QAPI and population health initiatives.

QM is a cross-functional, interdepartmental approach that works in tandem with our Care Management team and other areas. For example, we have made EPSDT a priority to address several of the State's program goals for promoting primary and preventive care through a comprehensive EPSDT strategy, overseen by our ***MCH/EPSDT Coordinator, Kaitlyn Dierks, BSN, RN***.

Member Services

Our Member Services team is often the first line of contact for members. They conduct community outreach, guide members through the complex health care system, and connect them to community resources, building trusting relationships with members and their families. They reflect members' cultural and linguistic backgrounds and make sure services and supports are culturally responsive to their needs and preferences. Under the leadership of our locally based CEO, ***Member Services Manager Jodi Payne*** oversees all aspects of our marketing and our Member Services functions for Nebraska, including our team of Member Services Representatives as well as our communication strategy, education, and outreach along with the approval and distribution of our member materials. Jodi brings 10 years of experience in health care settings and four years in community relations and outreach.

Provider Services

Our Provider Services team includes Network Development staff dedicated to provider contracting and Provider Experience staff dedicated to supporting physical and behavioral health providers to reduce complexity and administrative burden, including provider education and training. Our ***Provider Services Manager, Jamie Ferguson***, oversees the development, management, and maintenance of our comprehensive provider networks (including recruitment, credentialing, and dispute resolution processes) and our provider toll-free telephone line. Jamie is accountable for making sure all our Provider Services operations comply with contract

requirements and meet performance standards, in close coordination with other key staff. Jamie's six years in provider experience and vast knowledge of managed care has helped to strengthen the partnerships in Nebraska.

Program Integrity

Program Integrity (PI) includes multiple teams working together to assure proper payments to legitimate providers for reasonable services rendered to eligible members. At Healthy Blue, we work to continuously improve our programs for the benefit of members by fostering a culture of compliance at all levels of our organization. Our ***Contract Compliance Officer, Christine Cole***, leads our team to ingrain this culture among every employee working in support of our programs, making sure we remain a trusted partner to the State. Chris brings more than 10 years of experience across Medicaid managed care compliance, provider relations, and customer service. Working in close conjunction with Chris, our ***Program Integrity Officer, Jennifer Bohnhoff***, also plays a pivotal role in our efforts***.*** Jennifer oversees the monitoring, investigation, and enforcement of our fraud, waste, and abuse (FWA) program. With more than 16 years in senior-level compliance roles, she stays up to date on the latest trends as well as mechanisms for detecting FWA to assure our program integrity activities reflect the latest in best practices. She is also the primary point of contact to MLTC Program Integrity staff.

Claims and Encounters

Our Claims and Encounters team is responsible for processing Medicaid claims, claims adjustments and correspondence, and payment disputes; driving improvements with claim automation, productivity, and quality; and supporting growth, migrations, regulatory requirements, and audits. Healthy Blue's ***Claims Administrator, Leslie Langslow***, assures compliant encounter procedures and leads encounter data issue resolution. She brings 30 years of health care experience, including 22 years of Medicaid claims processing and adjudication, payment integrity, and cost of care initiatives. Leslie's team collaborates with the State to develop new system interfaces and resolve operational or system issues.

Shared Support Services

In addition to our local key leadership and staff, we augment our capabilities with strong national experience and support. Our organizational structure facilitates sharing of best practices across our affiliates. We collaborate to share and customize innovations successfully implemented in other affiliates, such as Virtual Translation Kiosks that provide on demand interpreter services for network providers or telehealth kits, which help members better manage their conditions including asthma, high blood pressure, diabetes, behavioral health issues, and high-risk pregnancies. As another example, our Welcome Room employees have access to the same technology and applications as our call center employees, so that they can easily assist members with new identification cards, changing their assigned PCPs, and more.

Shared services employees provide specialized centrally delivered services under the management of our local key leadership to support our health plan. These services include actuarial functions and information systems support, for example. These combined strengths mean that Nebraskans benefit from the collaboration and shared resources of a fully accountable local team, supported by our national team's years of cumulative institutional and customer knowledge and experience. As part of our management approach, we maintain a communication strategy and oversight structure that promotes coordination, collaboration, and accountability between local and shared support staff. We use technology, reporting capabilities, workgroups, committees, subcommittees, and other routine meetings to make sure that every functional area of the health plan has a regularly scheduled time to communicate with other related areas. Additionally, our key leadership routinely meets with national shared services leadership to discuss operational issues, process changes or enhancements, and priority issues.

Key Leadership Resumes

Healthy Blue's key leadership shape strategic actions to enhance our position as thought leaders for the Heritage Health program and drive innovation that improves the quality of health care we administer. These leaders reflect the skills, qualifications, and values we believe are paramount in fulfilling contract requirements and achieving the best possible outcomes for members. We provide resumes for each on the following pages.

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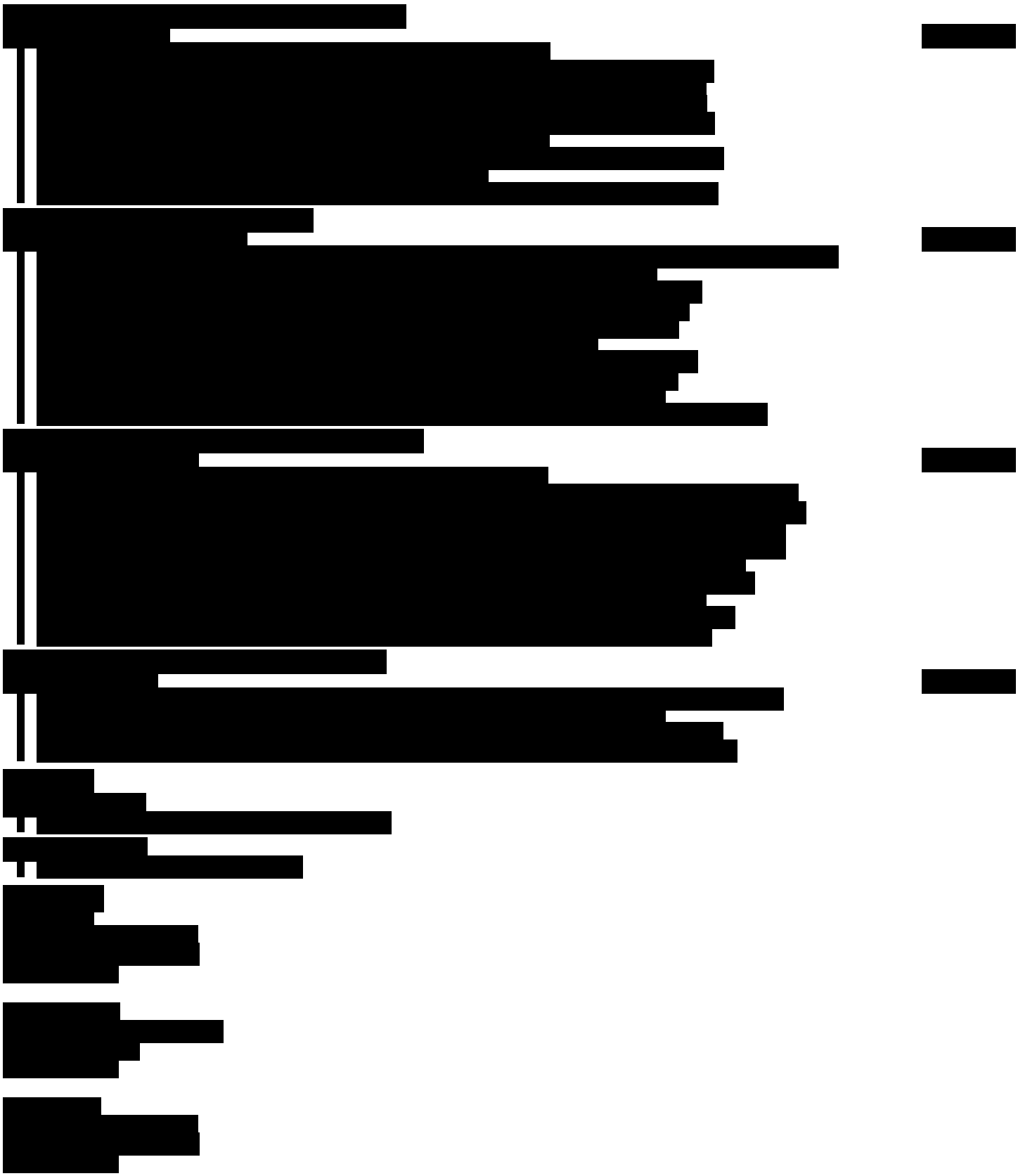

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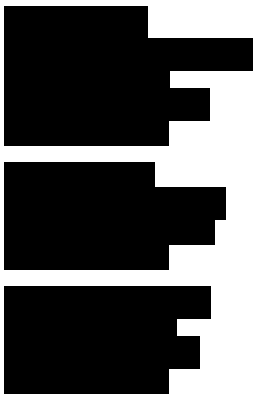

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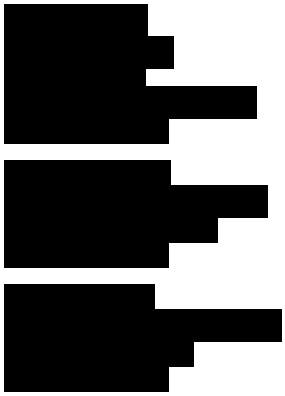

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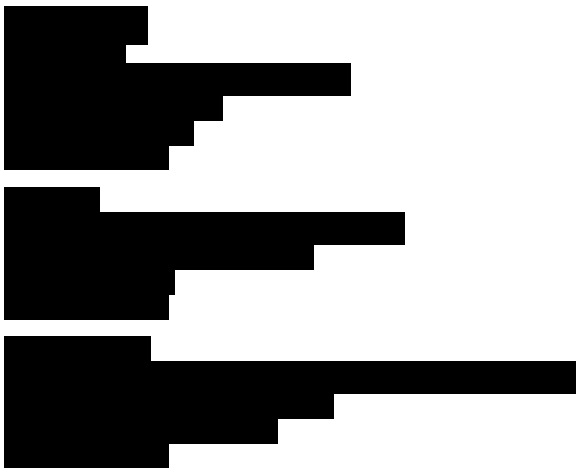

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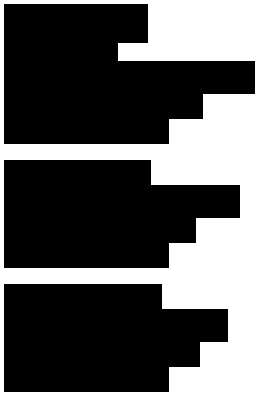

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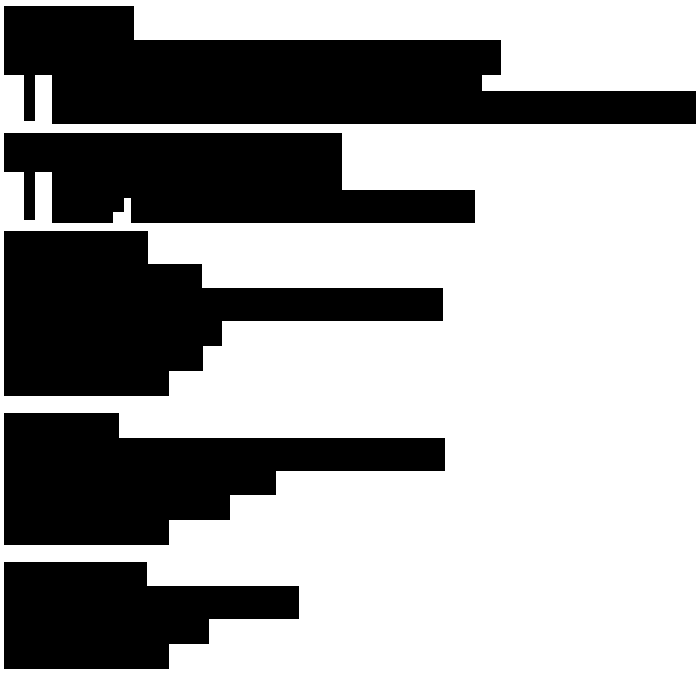

A.10 Subcontractors

Best-in-Class Subcontractors

Healthy Blue contracts with best-in-class subcontractors to complement our internal capabilities and deliver exceptional service to our members and providers. Our long-term business strategy includes selecting, monitoring, and building solid relationships with subcontractors who provide outstanding, fully integrated services that are seamless to our members and providers. Our subcontractors are an extension of Healthy Blue, and their involvement enables us to perform a variety of contract requirements in a way that is most responsive to local needs. Healthy Blue retains sole responsibility for fulfilling contract requirements and remains fully and solely accountable for our subcontractors' performance.

Table VI.A.10-1 lists the subcontractors we are proposing to support the Heritage Health program; a majority have already established a distinguished record of service in Nebraska. The following table provides contact and service information for each proposed subcontractor and an estimate of time each subcontractor will devote to supporting Heritage Health members and providers.

We calculated the percentage of performance hours for each subcontract by determining the number of FTE equivalents for each subcontract (one FTE equivalent equating to 40 performance hours per week). We then took the FTE equivalent count for each subcontract and divided that by the total count of FTE equivalents (inclusive of all subcontracts and the health plan). This provided us with the percentage of performance hours intended for each subcontract. To calculate the total percentage of subcontractor performance hours, we totaled the count of performance hours intended for each subcontract.

We have determined that the total percentage of subcontractors' performance hours is [redacted]. Of this number, [redacted] of work is performed in-house by either our parent company (Elevance Health) or affiliated subcontractors (AIM Specialty Health, Beacon Health Options, IngenioRx, and Meridian Resource Company).

Table VI.A.10-1. Healthy Blue Provides Our Subcontractor List, Specific Tasks, and Percentage of Performance Hours.

Subcontractor Name	Address	Telephone Number	Specific Tasks Subcontractor Is Performing	Percentage of Performance Hours
American Imaging Management, Inc. (d/b/a AIM Specialty Health)	8600 West Bryn Mawr Avenue, South Tower, Suite 800, Chicago, IL 60631	(800) 252-2021	Utilization management prior authorization review services for radiology, cardiology, radiation oncology, medical oncology, genetic testing, sleep therapy, and musculoskeletal	[redacted]
American Well (d/b/a Amwell)	75 State Street, Floor 26, Boston, MA 02109	(617) 204-3500	Telehealth services	[redacted]
Aunt Bertha, a Public Benefit Corporation (d/b/a findhelp)	3616 Far West Boulevard, Suite 117-454, Austin, TX 78731	(512) 717-0518	Referrals to community resources and social supports	[redacted]
Availity, LLC	5555 Gate Parkway, Suite 110, Jacksonville, FL 32256	(904) 470-4900	Electronic data services and provider engagement portal services	[redacted]
Beacon Health Options, Inc.	200 State Street, Suite 302, Boston, MA 02109	(888) 204-5581	Administration of behavioral health benefit	[redacted]
Centauri Health Solutions, Inc.	16260 North 71st Street, Suite 325, Scottsdale, AZ, 85254	(888) 447-8908	Identification of members that qualify for Supplemental Social Security Income (SSI) and Social Security Disability Insurance (SSDI)	[redacted]
Center for the Study of Services, Inc.	1625 K Street NW, Suite 800, Washington, DC 20006	(202) 347-9612	Market research surveys including CAHPS member and provider satisfaction surveys	[redacted]
Clarity Software Solutions, Inc.	92 Wall Street, Madison, CT 06443	(203) 453-3999	Member ID card production and fulfillment	[redacted]
ColorArt, LLC	101 Workman Court, Eureka, MO 63025	(314) 966-4725	Print fulfillment distribution of prenatal/postpartum packets	[redacted]
Conduent, Inc.	100 Campus Drive, Florham Park, NJ 07932	(844) 663-2638	Print and direct mail services for member communications	[redacted]
Conduent Credit Balance Solutions, LLC	100 Campus Drive, Suite 200, Florham Park, NJ 07932	(973) 526-7159	Credit balance auditing/processing	[redacted]

Subcontractor Name	Address	Telephone Number	Specific Tasks Subcontractor Is Performing	Percentage of Performance Hours
CERiS, Inc.	5128 Apache Plume Road, Suite 400, Fort Worth, TX 76109	(817) 348-0000	Pre-payment itemized bill reviews on inpatient hospital claims for billing accuracy	[redacted]
Cotiviti, Inc.	10897 S. River Front Parkway, #200, South Jordan, UT 84095	(801) 285-5800	Payment data validation services	[redacted]
Council for Affordable Quality Healthcare, Inc. (CAQH)	2020 K Street, NW Suite 900, Washington, DC 20006	(202) 517-0400	Identification of members with overlapping coverage	[redacted]
CQ fluency, Inc.	2 University Plaza Drive, Suite 406, Hackensack, NJ 07601	(201) 487-8007	Document translation services	[redacted]
CulturaLink LLC	157 Technology Parkway, Suite 600, Norcross, GA 30092	(404) 617-3800	Face-to-face language interpretation services	[redacted]
CyraCom International, Inc.	2650 E. Elvira Road, Suite 132, Tucson, AZ 85756	(520) 745-9447	Over-the-phone interpretation services	[redacted]
Direct Technologies, Inc.	600 Satellite Boulevard, Suwanee, GA 30024	(678) 288-1687	Print and direct mail services for member and provider communications	[redacted]
Elevance Health, Inc. (previously known as Anthem, Inc.)	220 Virginia Avenue, Indianapolis, IN 46204	(800) 331-1476	Administrative and support services including finance, claims administration, call center activities, information technology, legal, regulatory, treasury, and compliance	[redacted]
Health Management Systems, Inc. (HMS)	5615 High Point Drive, Irving, TX 75038	(214) 453-3000	Coordination of benefits services	[redacted]
HN1 Therapy Network, LLC	2001 South Andrews Avenue, Fort Lauderdale, FL 33316	(305) 614-0100	Physical therapy, speech therapy, and occupational therapy benefit management services	[redacted]
IngenioRx, Inc.	450 Headquarters Plaza, East Tower, 7th Floor, Morristown, NJ 07960	(833) 419-0530	Pharmacy Benefits Manager services	[redacted]
Lamont, Hanley & Associates, Inc.	1138 Elm Street, Manchester, NH 03101	(800) 639-2204	Third-party collection services for overpayments made to providers	[redacted]
Language Services Associates, Inc.	455 Business Center Drive, Suite 100, Horsham, PA 19044	(215) 259-7000	Over-the-phone Interpretation and in-person translation services	[redacted]
Liberty Dental Plan Corporation	340 Commerce, Suite 100, Irvine, CA 92602	(888) 273-2997	Dental benefit management services	[redacted]
Lone Star Consulting Services, LLC (d/b/a MES Peer Review Services)	100 Morse Street, Norwood, MA 02062	(800) 706-8427	Independent peer review services	[redacted]
Meridian Resource Company, LLC	N17W24340 Riverwood Drive, Waukesha, WI 53188	(800) 645-9785	Third-party liability recovery from tort and workers' compensation losses	[redacted]
ModivCare Solutions, LLC	6900 Layton Avenue, 12th Floor, Denver, CO 80237	(404) 888-5800	Non-Emergency Medical Transportation benefit administration	[redacted]

Subcontractor Name	Address	Telephone Number	Specific Tasks Subcontractor Is Performing	Percentage of Performance Hours
MPulse Mobile, Inc. (previously CrowdCircle)	16530 Ventura Boulevard, #500, Encino, CA 91436	(888) 678-5735	Member outreach via interactive voice response, text messaging, and email to improve HEDIS® scores	[redacted]
OneTouchPoint Corp.	1225 Walnut Ridge Drive, Hartland, WI 53029	(800) 332-2348	Print and direct mail services and implementation of digital storefront	[redacted]
Preferred Direct Marketing Services, Inc.	4590 Village Avenue, Norfolk, VA 23502	(757) 461-2730	Print and direct mail services including member handbooks	[redacted]
Prest & Associates, LLC	401 Charmany Drive, Suite 305, Madison, WI 53719	(800) 952-5129	Independent medical necessity reviews	[redacted]
R.R. Donnelley & Sons Company	35 W. Wacker Drive, Chicago, IL 60601	(800) 742-4455	Print and direct mail services	[redacted]
Superior Vision Benefit Management, Inc.	881 Elkridge Landing Road, Suite 300, Baltimore, MD 21090	(410) 752-0121	Vision benefit management services	[redacted]
Teladoc Health, Inc. (d/b/a Livongo Health)	2 Manhattanville Road, Suite 203, Purchase, NY 10577	(203) 635-2002	Diabetes chronic care management support services	[redacted]
The Dieringer Research Group, Inc.	200 Bishops Way, Brookfield, WI 53005	(262) 432-5200	Member experience surveys	[redacted]
			Total Percentage of Performance Hours:	[redacted]

CALLED TO CARE - Brittany Kuhns, Clinical Quality Program Manager

A Nebraska native, I have worked in Medicaid for the past 5.5 years and am passionate about helping members better their lives. Help comes in many different forms. When I was conducting a 30-day follow-up on a member who had recently been discharged from the Emergency Department, she began crying and said she didn't feel good. I was making a referral to Care Management so they could help her find a therapist when she told me that she and her partner were fighting and she didn't feel safe. I gave her contact information for a local domestic abuse center. When I called back later that night, she assured me that she made it to a safe place and thanked me for my help.

CALLED TO CARE: My journey to working in Medicaid is very personal. When I had my first child, I was in college with a part-time job. I had to apply for Medicaid and, at that time, Medicaid was not handled by managed care companies, so I received basic prenatal care. When I learned that managed care was being introduced in Nebraska, I was excited for the opportunity to better serve Medicaid members beyond basic coverage. I wanted to make a difference in their lives.

Corporate Overview Attachments

Healthy Blue

Tackling Food Insecurity

Healthy Blue contributed a new refrigerated van to support No More Empty Pots in Omaha and surrounding areas.

Attachment VI.A.2-1: Healthy Blue Financial Statements

Healthy Blue

Financial Statements and Supplementary Information - Statutory Basis

Community Care Health Plan of Nebraska, Inc.

Years Ended December 31, 2021 and 2020
With Reports of Independent Auditors

Community Care Health Plan of Nebraska, Inc.

Financial Statements and Supplementary Information - Statutory Basis

Years ended December 31, 2021 and 2020

Contents

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Building a better working world

Report of Independent Auditors

Board of Directors
Community Care Health Plan of Nebraska, Inc.

Opinion

We have audited the statutory basis financial statements of Community Care Health Plan of Nebraska, Inc. (the Company), which comprise the balance sheets of December 31, 2021 and 2020 and the related statements of operations, changes in capital and surplus and cash flow for the years ended, and the related notes to the financial statements (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note 1.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company at December 31, 2021 and 2020, or the results of its operations or its cash flows for the years then ended.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1 to the financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Nebraska Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in Note 1 and accounting principles generally

accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Nebraska Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are issued.

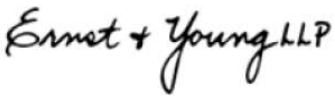
Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.



April 8, 2022

Community Care Health Plan of Nebraska, Inc.

Balance Sheets - Statutory Basis

	December 31	
	2021	**2020**
	(In Thousands)	
Admitted assets		
Cash and invested assets:		
Cash, cash equivalents and short-term investments	**$ 17,801**	$ 25,348
Bonds	**209,299**	113,761
Total cash and invested assets	**227,100**	139,109
Accrued investment income	**1,038**	799
Premiums receivable	**22,808**	34,263
Current federal income tax recoverable	**1,757**	—
Net deferred tax asset	**4,324**	5,584
Health care and other receivables	**110**	76
Total admitted assets	**$ 257,137**	$ 179,831
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	**$ 83,246**	$ 73,702
Aggregate policy reserves	**52,543**	4,831
Current federal income tax payable	**—**	482
Accounts payable and accrued expenses	**2,428**	13,290
Remittances and items not allocated	**3,047**	—
Payable to affiliates	**3,220**	3,992
Liability for amounts held under uninsured plans	**10,847**	7,659
Other liabilities	**11,659**	6,141
Total liabilities	**166,990**	110,097
Capital and surplus:		
Common stock, $1 par value, 1,000 shares authorized, 105 shares issued and outstanding	**—**	—
Additional paid-in surplus	**42,199**	42,199
Unassigned surplus (deficit)	**47,948**	27,535
Total capital and surplus	**90,147**	69,734
Total liabilities and capital and surplus	**$ 257,137**	$ 179,831

See accompanying notes.

Community Care Health Plan of Nebraska, Inc.

Statements of Operations - Statutory Basis

	Year Ended December 31	
	2021	**2020**
	(In Thousands)	
Premium income	**$ 526,518**	$ 404,776
Benefits and expenses:		
Claims and claims adjustment expenses	**473,982**	351,023
Operating expenses	**27,423**	48,379
Total benefits and expenses	**501,405**	399,402
Net underwriting gain (loss)	**25,113**	5,374
Investment gains (losses):		
Net investment income (losses)	**3,309**	2,452
Net realized capital gains (losses), net of taxes (benefits)	**(76)**	(11)
Total net investment gains (losses)	**3,233**	2,441
Other income (expense)	**378**	—
Income (loss) before federal income taxes	**28,724**	7,815
Federal income taxes (benefits)	**2,395**	442
Net income (loss)	**$ 26,329**	$ 7,373

See accompanying notes.

Community Care Health Plan of Nebraska, Inc.

Statements of Changes in Capital and Surplus - Statutory Basis

	Common Stock	Additional Paid-in Surplus	Unassigned Surplus (Deficit)	Special Surplus Funds	Total Capital and Surplus
			(In Thousands)		
Balance as of January 1, 2020	$ —	$ 31,900	$ 23,117	$ 6,509	$ 61,526
Net income (loss)	—	—	7,373	—	7,373
Change in net unrealized capital gains and losses, net of taxes (benefits)	—	—	(26)	—	(26)
Change in net deferred income tax	—	—	22,286	—	22,286
Change in nonadmitted assets	—	—	(16,724)	—	(16,724)
Change in special surplus funds for ACA health insurer fee	—	—	6,509	(6,509)	—
Dividend to shareholder	—	—	(15,000)	—	(15,000)
Capital contributions from parent	—	10,299	—	—	10,299
Balance as of December 31, 2020	$ —	$ 42,199	$ 27,535	$ —	$ 69,734
Net income (loss)	**—**	**—**	**26,329**	**—**	**26,329**
Change in net unrealized capital gains and losses, net of taxes (benefits)	**—**	**—**	**(58)**	**—**	**(58)**
Change in net deferred income tax	**—**	**—**	**(805)**	**—**	**(805)**
Change in nonadmitted assets	**—**	**—**	**(5,053)**	**—**	**(5,053)**
Balance as of December 31, 2021	**$ —**	**$ 42,199**	**$ 47,948**	**$ —**	**$ 90,147**

See accompanying notes.

Community Care Health Plan of Nebraska, Inc.

Statements of Cash Flow - Statutory Basis

	Year Ended December 31	
	2021	**2020**
	(In Thousands)	
Operating activities:		
Premiums collected	**$ 585,684**	$ 380,085
Investment income received	**4,158**	3,108
Claims and claims adjustment expenses paid	**(467,850)**	(330,478)
General administrative and miscellaneous expenses paid	**(34,732)**	(58,204)
Federal income taxes (paid) recovered	**(4,662)**	(921)
Net cash provided by (used in) operating activities	**82,598**	(6,410)
Investment activities:		
Proceeds from investments sold, matured or repaid	**23,069**	26,937
Cost of investments acquired	**(119,802)**	(53,422)
Net cash provided by (used in) investment activities	**(96,733)**	(26,485)
Financing or miscellaneous activities:		
Capital contributions from parent	**—**	9,260
Dividend to shareholder	**—**	(15,000)
Net transfers from (to) affiliates	**(772)**	3,788
Other	**7,360**	6,820
Net cash provided by (used in) financing or miscellaneous activities	**6,588**	4,868
Change in cash, cash equivalents and short-term investments	**(7,547)**	(28,027)
Cash, cash equivalents and short-term investments at beginning of year	**25,348**	53,375
Cash, cash equivalents and short-term investments at end of year	**$ 17,801**	$ 25,348

See accompanying notes.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis

(Dollars In Thousands)

December 31, 2021

1. Nature of Operations and Significant Accounting Policies

Community Care Health Plan of Nebraska, Inc. (the "Company") is a Nebraska domiciled stock insurance company which is owned 95% by Anthem Partnership Holding Company, LLC ("APHC"), which is an indirect wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company, and 5% by Blue Cross and Blue Shield of Nebraska, Inc. ("BCBSNE"), an unaffiliated nonprofit insurance company.

On September 26, 2019, WellCare Health Plans, Inc. ("WellCare") entered into a definitive agreement with Anthem under which Anthem would acquire the Company after WellCare's merger with Centene Corporation. On January 23, 2020, upon satisfaction of all required regulatory approvals and customary closing conditions, immediately prior to the closing of the Centene Merger Agreement, the Company was acquired by Anthem.

On August 10, 2020, the Company was renamed Community Care Health Plan of Nebraska, Inc. and the Company's parent became APHC, which is an affiliated company of the Company's former parent, ATH Holding Company LLC. ("ATH Holding"). Prior to the Anthem purchase on January 23, 2020, the Company's direct parent was The WellCare Management Group ("WCMG").

On October 1, 2020, BCBSNE purchased 5% of the common stock of the Company. With this purchase, BCBSNE now owns 5% of CCHPNE and APHC owns the remaining 95%.

On October 13, 2020, the Company became a regulated Blue Cross and Blue Shield Association ("BCBSA") licensee.

A contract with the State of Nebraska (the "State") authorized and enabled the Company to begin operating as a licensed provider of group and individual health insurance, offering Health Maintenance Organization health insurance to Medicaid enrollees in all regions of Nebraska. The Company's contract began on January 1, 2017, with an initial five-year term and may be renewed for two additional one-year periods when mutually agreeable to the Company and the State. The loss of this contract would have a material effect on the Company's operations.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Nebraska Department of Insurance (the "Department"). The Department has adopted the Statement of Statutory Accounting Principles ("SSAP") found in the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP") as a component of prescribed accounting practices. For the

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

years ended December 31, 2021 and 2020, there were no differences between the Company's statutory net income or capital and surplus under NAIC SAP and practices prescribed or permitted by the Department.

Various statutory accounting principles differ from U.S. generally accepted accounting principles ("GAAP"). The more significant differences from GAAP, applicable to the Company, are as follows:

Investments: Investments in bonds are reported at amortized cost or fair value based on their NAIC rating. Changes in value in investments carried at fair value are included in unassigned surplus. Other than temporary impairments ("OTTI") of bonds result in a permanent write-down in the carrying value of the investment. For GAAP, investments in bonds designated at purchase as available-for-sale are reported at fair value with unrealized holding gains and losses, net of tax, reported as a separate component of capital and surplus. Impairments of bonds are reflected in a valuation allowance, which is adjusted for improvements in the fair value of the investment.

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally, amounts aged ninety days and older are nonadmitted assets, with the exception of government receivables. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the expected collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, including deferred federal income taxes in excess of certain statutory limits, furniture and equipment, non-operating software, prepaid expenses, certain health care and other receivable balances, are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled $23,115 and $18,062 at December 31, 2021 and 2020, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Income taxes: Statutory deferred tax assets are subject to certain statutory limitations with amounts in excess of these limitations being nonadmitted. Changes in deferred taxes are recognized as a separate component of gains and losses in unassigned surplus ("Change in net deferred income tax"). State income taxes are included as a component of operating expenses but are not considered in the computation of deferred taxes. In addition, income taxes on investment realized gains and losses are reported as a component of net realized capital gains (losses). For GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years and a valuation allowance is

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of operations. State income taxes are considered in the computation of deferred taxes and are included as a component of income tax expense. Income taxes on investment realized gains and losses are included as a component of income tax expense.

Statements of cash flow: Cash, cash equivalents and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of less than one year and more than three months at the date of acquisition. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less. Short-term investments are reported separately, and negative cash balances are reported separately as liabilities.

Uninsured accident and health plans: The Company provides administrative services to various customers on an uninsured basis. Administrative fees earned under these arrangements are deducted from operating expenses. For GAAP, these administrative fees are reported as revenue in the statements of operations.

Reinsurance: Any reinsurance balance amounts deemed to be uncollectible are written off through a charge to operations. In addition, a liability for reinsurance balances is provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus. Under GAAP, an allowance for amounts deemed uncollectible is established through a charge to earnings. Claim and policy liabilities ceded to reinsurers are reported as reductions of the related reserves rather than as assets, as would be required under GAAP.

Leases: Obligations under noncancelable operating leases are not reflected on the balance sheet. Under GAAP, all lease obligations are reported as liabilities along with an asset representing its right to use the underlying assets over the lease terms adjusted for initial direct costs, prepaid lease payments and lease incentives.

The effects of the foregoing variances from GAAP on the accompanying statutory financial statements have not been determined but are presumed to be material.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

Other significant accounting policies are as follows:

Use of Estimates

Preparation of statutory financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

Bonds not backed by loans are stated at amortized cost, with amortization of premium or discount calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Single class and multi-class mortgage-backed/asset-backed securities are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade bonds are stated at the lower of cost or fair value.

The Company holds 7 SVO-Identified bond exchange-traded funds ("ETFs") and has made an irrevocable decision to report these ETFs as bonds valued using the systematic value approach to amortize or accrete the investment in a manner that represents the expected cash flows from the underlying bond holdings. Systematic valuation has been consistently applied to these ETFs held at December 31, 2021 and previous periods.

The Company holds 4 SVO-Identified bond ETFs that are reported at fair value. These ETFs do not qualify for systematic value because the NAIC designation at the time of acquisition was not a 1 or 2. These ETFs have been consistently reported at fair value as of December 31, 2021 and previous periods.

Unrealized losses on non-investment grade bonds are reflected directly in unassigned surplus, net of federal income taxes, unless there is deemed to be an other-than-temporary decline in value, in which case the loss is charged to income. Realized gains and losses on investments sold are determined using the specific identification method and are included in net realized capital gains (losses), net of taxes (benefits). Investment income is not accrued on bonds with interest payments in default.

In accordance with SSAP No. 26R, *Bonds*, it is the Company's policy to assess for OTTI when fair value falls below amortized cost and record an OTTI when it becomes probable that the

Company will be unable to collect all amounts due according to the contractual terms of the security in effect at the date of acquisition. In accordance with SSAP No. 43 Revised, *Loan-backed and Structured Securities* ("SSAP No. 43R"), OTTI on loan-backed or structured securities are recorded when fair value of the security is less than its amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis or (3) if the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the investment and the Company has the intent and ability to hold the investment.

Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Cash equivalent investments include money market mutual funds and investments with maturities of less than or equal to three months at the date of acquisition. Money market mutual funds are reported at fair value. Investments with maturities of less than or equal to three months at the date of acquisition are reported at amortized cost, which approximates fair value. Non-investment grade short-term and cash equivalent investments are stated at the lower of amortized cost or fair value.

Furniture, Fixtures and Leasehold Improvements

Furniture, fixtures and leasehold improvements are capitalized and depreciated on a straight-line basis over its useful life. The net book value is charged in full to unassigned surplus as a nonadmitted asset. Depreciation expense in 2021 and 2020 was $746 and $169, respectively. Accumulated depreciation at December 31, 2021 and 2020 was $915 and $169, respectively.

Health Care Receivables

Health care receivables represent amounts related to pharmacy rebate receivables and other health care related receivables other than premiums. Pharmacy rebate receivables are recorded when earned, based upon actual rebate receivables and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. Health care receivables are subject to various admittance tests based on the nature of the receivable balance. Health care receivables relating to insured plans are reported in health care and other receivables. Health care receivables that are not for insured plans are included in amounts receivable relating to uninsured plans on the statutory balance sheets.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claims adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

There were no significant changes in methodologies and assumptions used in calculating the liability for unpaid claims and claims adjustment expenses.

Provider Risk Share and Other Reserves

The Company contracts with physicians or provider groups to provide medical services to the Company's members. The Company pays capitation or negotiated fees for defined services provided by the physicians. Under the terms of these agreements, certain providers are eligible to receive provider incentives based on qualitative and quantitative factors. Estimated risk-sharing settlements are continually reviewed, and necessary adjustments are included in current operations. Claims and claims adjustment expenses include all amounts incurred by the Company under these arrangements.

Premium Deficiency Reserves

Premium deficiency reserves are established for the amount of the anticipated claims and claims adjustment expenses that have not been previously expensed in excess of the recorded unearned premium reserve and future premiums on existing policies. The Company does not use anticipated investment income as a factor in the premium deficiency reserve calculation. The Company did not record premium deficiency reserves as of December 31, 2021 or 2020.

Revenue Recognition

Premiums are earned over the coverage term of the related insurance policies and reinsurance contracts. Unearned premium reserves, included in aggregate policy reserves, are established to cover the unexpired portion of premiums written and collected, and are computed by pro rata methods for direct business, and are based on reports received from ceding companies for

reinsurance assumed. Expenses incurred in connection with acquiring new insurance business, including acquisition costs such as sales commissions, are charged to operations as incurred. The premiums paid by policyholders prior to the effective date are recorded in the balance sheets as premiums received in advance and subsequently recorded to income as earned during the coverage period. Premium rates for certain lines of business are subject to approval by the Department.

Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized, dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Funds received from the State, representing pass through payments to be paid to hospitals and other health care providers, in which the Company does not assume insurance risk, are excluded from the Company's statutory statements of operations.

At December 31, 2021 and 2020, the Company reported admitted assets of $22,808 and $34,263, respectively, in premiums receivables. The receivables are not deemed to be uncollectible, therefore, no provision for uncollectible amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

Reinsurance

Reinsurance premiums and claims and claims adjustment expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Certain premiums and benefits are ceded to other insurance companies under various reinsurance contracts. These reinsurance contracts limit the Company's exposure to losses within its capital resources. The Company remains obligated for amounts ceded in the event that the reinsurers do not meet their obligations. Uncollected premiums receivable and unpaid claims are reported net of reinsurance amounts ceded to other insurers. A liability for reinsurance balances is provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus.

Retrospectively Rated Contracts

The Company sells policies where premiums vary based on loss experience or premium stabilization programs. Premium income includes an adjustment for retrospectively rated refunds based on an estimate of incurred claims. A retrospectively rated contract is one that has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy). The Company's contracts with the State include a provision for which premiums vary based on loss experience. Accrued retrospective premiums are reported in premiums receivable. Reserves for rate credits or policy rating refunds are reported in aggregate policy reserves.

The Company uses estimates to report in the statutory financial statements to determine the receivable and reserve amounts for these arrangements based on estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory financial statements and related footnote disclosures may differ from actual results.

All of the Company's premiums written in 2021 and 2020 are subject to retrospective rating features.

Uninsured Accident and Health Plans

The Company provides administrative services to various customers on an uninsured basis. Under these arrangements, the customer retains the risk of funding payments for health benefits provided, and the Company may be subject to credit risk of the customer from the time of the Company's claim payment until the Company receives the claim reimbursement. In accordance with SSAP No. 47, *Uninsured Plans*, these claims payments and subsequent reimbursements are excluded from the Company's statutory statements of operations. Administrative fees for administering these arrangements are recognized as administrative services are performed and recorded as a reduction to operating expenses.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service ("IRS") due dates.

Deferred tax assets ("DTA") are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level ("ACL") Risk Based Capital ("RBC") ratio exclusive of the DTA, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200% and 300%, or (c) if the ratio is below 200%, no DTA can be realized; and (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities ("DTL"). DTAs in excess of these limitations are nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax").

Health Insurer Fee

Affordable Care Act ("ACA") Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that were written during the preceding calendar year. This fee is non-deductible for income tax purposes. The health insurer fee is reported in operating expenses in the same year it is paid. The health insurer fee to be paid in the following year is segregated in special surplus funds until the beginning of the year in which it is to be paid. The health insurer fee was temporarily suspended for 2019 and resumed in 2020. The health insurer fee has been permanently eliminated, beginning in 2021.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

2. Investments

A summary of the Company's investments in bonds is as follows:

December 31, 2021	Statement Value	Gross Unrealized Gains	Gross Unrealized Losses: Less Than 12 Months	Gross Unrealized Losses: 12 Months or Greater	Fair Value
United States government securities	**$ 18,512**	**$ 7**	**$ (16)**	**$ (777)**	**$ 17,726**
States, territories and political subdivisions	**8,105**	**279**	**(1)**	**—**	**8,383**
Industrial and miscellaneous	**153,261**	**1,389**	**(844)**	**—**	**153,806**
Loan-backed and structured securities	**29,421**	**—**	**(297)**	**—**	**29,124**
Total bonds	**$ 209,299**	**$ 1,675**	**$ (1,158)**	**$ (777)**	**$ 209,039**
December 31, 2020					
United States government securities	$ 12,961	$ 1	$ (231)	$ —	$ 12,731
States, territories and political subdivisions	8,209	149	(1)	—	8,357
Industrial and miscellaneous	92,551	3,545	—	—	96,096
Loan-backed and structured securities	40	—	—	—	40
Total bonds	$ 113,761	$ 3,695	$ (232)	$ —	$ 117,224

The statement and fair values of bonds at December 31, 2021, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Statement Value	Fair Value
Due in one year or less	**$ 24,307**	**$ 24,536**
Due after one through five years	**66,289**	**67,283**
Due after five through ten years	**37,452**	**36,287**
Due after ten years	**51,830**	**51,809**
Loan-backed and structured securities	**29,421**	**29,124**
	$ 209,299	**$ 209,039**

Proceeds from sales of bonds during 2021 and 2020 were $15,254 and $15,301, respectively. The Company realized gross gains of $92 and gross losses of $138, during 2021, and gross gains of $164 and gross losses of $136 during 2020.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

Investments with a statement value of $360 and $368 were on deposit with the Department at December 31, 2021 and 2020, respectively.

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. The Company follows a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. The Company has established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information.

The impairment review process considers a number of factors, including but not limited to (a) the length of time and the extent to which a security's fair value has been less than statement value; (b) the financial condition and near term prospects of the issuer; (c) the intent to sell, and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in value; (d) whether the debtor is current on interest and principal payments; (e) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (f) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to its fair value or present value of its discounted cash flows, and the resulting losses are recognized in net realized gains or losses in the statutory statements of operations. The new cost basis of the impaired securities is not increased for future recoveries in fair value. The Company did not recognize OTTI on securities for the years ended December 31, 2021 and 2020.

A summary of unaffiliated investments with unrealized losses along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

	December 31, 2021			**December 31, 2020**		
	Number of Securities	**Fair Value**	**Gross Unrealized Loss**	**Number of Securities**	**Fair Value**	**Gross Unrealized Loss**
Bonds:						
Less than 12 months	**53**	**$ 86,353**	**$ (1,158)**	2	$ 10,657	$ (232)
12 months or greater	**2**	**12,190**	**(777)**	—	—	—
Total bonds	**55**	**$ 98,543**	**$ (1,935)**	2	$ 10,657	$ (232)

The Company's bond portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses on bonds reported above were primarily caused by the effects of the interest rate environment and the widening of credit spreads on certain securities. The Company currently has the ability and intent to hold these securities until their full cost can be recovered. Therefore, the Company does not believe the unrealized losses represent an OTTI as of December 31, 2021 or 2020.

The Company is required to categorize its loan-backed and structured securities by the reason for which the Company recognized an OTTI during the years ended December 31, 2021 and 2020. The Company did not recognize an OTTI on loan-backed and structured securities in 2021 and 2020.

The Company had 4 securities sold, redeemed and otherwise disposed as a result of a call feature or tender offer (including make-whole call provisions) during both years ended December 31, 2021 and 2020. The aggregate investment income generated as a result of prepayment penalties and/or acceleration fees during the years ended December 31, 2021 and 2020 was $179 and $155, respectively.

3. Fair Value

Assets and liabilities recorded at fair value in the statutory balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

Level Input	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The following table summarizes the assets and/or liabilities measured and reported at fair value in the balance sheets as of December 31, 2021 and 2020, respectively:

	Level I	Level II	Level III	Total
December 31, 2021				
SVO identified bonds	**$ 7,658**	**$ —**	**$ —**	**$ 7,658**
Total bonds	**7,658**	**—**	**—**	**7,658**
Industrial and miscellaneous money market funds	**6,000**	**—**	**—**	**6,000**
Total cash equivalents	**6,000**	**—**	**—**	**6,000**
Total assets at fair value	**$ 13,658**	**$ —**	**$ —**	**$ 13,658**
December 31, 2020				
Industrial and miscellaneous money market funds	$ —	$ 1,839	$ —	$ 1,839
Total cash equivalents	—	1,839	—	1,839
Total assets at fair value	$ —	$ 1,839	$ —	$ 1,839

Fair values of bonds are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs, for the determination of fair value and to facilitate fair value measurements and disclosures. Level II securities primarily include United States government securities, corporate securities, securities from states, municipalities and political subdivisions, residential mortgage-backed securities and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. For certain investments in bonds, primarily corporate debt securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets. These securities are designated Level III.

Cash equivalents primarily consist of highly rated money market funds or bonds with original maturities of three months or less. Due to the high ratings and short-term nature of these investments, they are designated as Level I. The fair value of certain bonds purchased with less than three months to maturity are based on quoted market prices obtained from third party pricing services, which may use Level II inputs.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The Company has controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, the Company periodically reviews the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

There were no securities reported at fair value on the statutory balance sheets using Level III inputs during the years ended December 31, 2021 and 2020. There were no transfers between levels during the years ended December 31, 2021 and 2020. The Company's policy is to recognize transfers between levels, if any, as of the beginning of the reporting period.

The following table summarizes the fair value of financial instruments by types:

December 31, 2021

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	Level I	Level II	Level III
Bonds	**$ 209,039**	**$ 209,299**	**$ 44,438**	**$ 164,601**	**$ —**
Cash equivalents	**6,000**	**6,000**	**6,000**	**—**	**—**

December 31, 2020

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	Level I	Level II	Level III
Bonds	$ 117,224	$ 113,761	$ —	$ 117,224	$ —

The Company has no investments measured at net asset value.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

4. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	2021	2020
Balances at January 1	**$ 73,702**	$ 55,408
Incurred (redundancies) related to:		
Current year	**488,996**	353,760
Prior years	**(15,014)**	(2,737)
Total incurred	**473,982**	351,023
Paid related to:		
Current year	**420,324**	291,866
Prior years	**44,114**	40,863
Total paid	**464,438**	332,729
Balances at December 31	**$ 83,246**	$ 73,702

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred claims related to prior years are due to claims being settled for amounts less than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established. The impact from COVID-19 on healthcare utilization and medical claims submission patterns has increased estimation uncertainty on our incurred but not reported liability at December 31, 2021. Slowdowns in claims submission patterns and increases in utilization levels for COVID-19 testing and treatment during the fourth quarter of 2021 are the primary factors that lead to the increased estimation uncertainty.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

5. Reinsurance

The Company cedes certain direct claims under an excess of loss arrangement to Anthem Insurance Companies, Inc., an affiliated company and an authorized reinsurer. Under this affiliate reinsurance contract, ceded premiums of $51 and ceded claims of $0 were included in operating results for the years ended December 31, 2021. Ceded unpaid claims and claims adjustment expenses of $0 were included in the statutory balance sheets as of December 31, 2021.

The effects of reinsurance on net premiums are as follows:

	Year ended December 31	
	2021	**2020**
Direct premiums	**$ 526,569**	$ 404,819
Ceded premiums - affiliated reinsurers	**(51)**	—
Ceded premiums - unaffiliated reinsurers	**—**	(43)
Net premiums	**$ 526,518**	$ 404,776

The effects of reinsurance on claims and claims adjustment expenses in the accompanying financial statements as follows:

	Year ended December 31	
	2021	**2020**
Direct claims and claims adjustment expenses	**$ 473,982**	$ 351,021
Ceded claims and claims adjustment expenses - unaffiliated reinsurers	**—**	2
Net claims and claims adjustment expenses	**$ 473,982**	$ 351,023

6. Federal Income Taxes

The Company has a current federal income tax recoverable (payable) of $1,757 and ($482) as of December 31, 2021 and 2020, respectively.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	2021		
	Ordinary	**Capital**	**Total**
Gross deferred tax assets	**$ 22,200**	**$ 49**	**$ 22,249**
Gross deferred tax liabilities	**—**	**—**	**—**
Net deferred tax asset before admissibility test	**$ 22,200**	**$ 49**	**$ 22,249**

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes* ("SSAP No. 101") as of December 31, 2021 is:

Admitted pursuant to paragraph 11.a.	**$ 4,296**	**$ 28**	**$ 4,324**
Admitted pursuant to paragraph 11.b.	**—**	**—**	**—**
Admitted pursuant to paragraph 11.c.	**—**	**—**	**—**
Admitted deferred tax asset	**4,296**	**28**	**4,324**
Deferred tax liability	**—**	**—**	**—**
Net admitted deferred tax asset	**4,296**	**28**	**4,324**
Nonadmitted deferred tax asset	**$ 17,904**	**$ 21**	**$ 17,925**

	2020		
	Ordinary	**Capital**	**Total**
Gross deferred tax assets	$ 23,041	$ —	$ 23,041
Gross deferred tax liabilities	2	—	2
Net deferred tax asset before admissibility test	$ 23,039	$ —	$ 23,039

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2020 is:

	Ordinary	**Capital**	**Total**
Admitted pursuant to paragraph 11.a.	$ 1,912	$ —	$ 1,912
Admitted pursuant to paragraph 11.b.	3,672	—	3,672
Admitted pursuant to paragraph 11.c.	2	—	2
Admitted deferred tax asset	5,586	—	5,586
Deferred tax liability	2	—	2
Net admitted deferred tax asset	5,584	—	5,584
Nonadmitted deferred tax asset	$ 17,455	$ —	$ 17,455

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The change in the amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 during 2021 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a.	$ 2,384	$ 28	$ 2,412
Admitted pursuant to paragraph 11.b.	(3,672)	—	(3,672)
Admitted pursuant to paragraph 11.c.	(2)	—	(2)
Admitted deferred tax asset	(1,290)	28	(1,262)
Deferred tax liability	(2)	—	(2)
Net admitted deferred tax asset	(1,288)	28	(1,260)
Nonadmitted deferred tax asset	$ 449	$ 21	$ 470

	2021	2020
Ratio percentage used to determine recovery period and threshold limitation amount	**445 %**	447 %
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations	**$ 85,823**	$ 64,150

The impact of tax planning strategies is as follows:

	2021		2020		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	**$22,200**	**$ 49**	$23,041	$ —	$ (841)	$ 49
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	**0.00 %**	**0.00 %**	0.00 %	0.00 %	0.00 %	0.00 %
Net admitted adjusted gross deferred tax assets amount	**$ 4,296**	**$ 28**	$ 5,586	$ —	$ (1,290)	$ 28
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	**0.00 %**	**0.00 %**	0.00 %	0.00 %	0.00 %	0.00 %

The Company’s tax planning strategies do not include the use of reinsurance.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

Current federal income taxes (benefits) consist of the following major components:

	2021	2020	Change
Federal income taxes (benefits) on operations	**$ 2,395**	$ 442	$ 1,953
Federal income tax expense (benefit) on net capital gains (losses)	**28**	40	(12)
Federal income taxes	**$ 2,423**	$ 482	$ 1,941

The components of deferred income taxes are as follows:

	December 31		
	2021	2020	Change
Deferred tax assets:			
Ordinary:			
Amortization	**$ 20,604**	$ 22,162	$ (1,558)
Accounts receivable	**775**	81	694
Claims discount reserve	**238**	165	73
Fixed assets	**100**	—	100
Other insurance reserves	**462**	630	(168)
Prepaid expenses	**12**	—	12
Other adjustments	**9**	3	6
Subtotal	**22,200**	23,041	(841)
Nonadmitted deferred tax assets	**17,904**	17,455	449
Admitted ordinary deferred tax assets	**4,296**	5,586	(1,290)
Capital:			
Investments in securities	**49**	—	49
Subtotal	**49**	—	49
Nonadmitted deferred tax assets	**21**	—	21
Admitted capital deferred tax assets	**28**	—	28
Admitted deferred tax assets	**4,324**	5,586	(1,262)
Deferred tax liabilities:			
Ordinary:			
Other adjustments	**—**	2	(2)
Subtotal	**—**	2	(2)
Deferred tax liabilities	**—**	2	(2)
Net admitted deferred tax asset (liability)	**$ 4,324**	$ 5,584	$ (1,260)

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31 2021	2020	Change
Total deferred tax assets	**$ 22,249**	**$ 23,041**	$ (792)
Total deferred tax liabilities	**—**	**2**	(2)
Net deferred tax asset	**$ 22,249**	**$ 23,039**	(790)
Tax effect of unrealized gains (losses)			(15)
Change in net deferred income tax			$ (805)

The Company has no repatriation transition tax or alternative minimum tax credit.

The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 21% for the years ended December 31, 2021 and 2020 as follows:

	2021	2020
Tax expense (benefit) computed using the federal statutory rate	**$ 6,038**	$ 1,650
Change in nonadmitted assets	**(963)**	154
Tax exempt income net of proration	**(19)**	(10)
Prior year true-ups and adjustments	**(1,828)**	6
Tax impact of section 338(h)(10) election	**—**	(23,604)
Total	**$ 3,228**	$ (21,804)
Federal income taxes expense (benefit)	**$ 2,423**	$ 482
Change in net deferred income taxes	**805**	(22,286)
Total statutory income taxes	**$ 3,228**	$ (21,804)

A 338(h)(10) is a tax election for a qualified stock purchase, which re-characterizes a stock purchase as an asset purchase for federal tax purposes. It remains a stock purchase for all other legal purposes. The deemed asset purchase for federal tax purposes provides a step up in the tax basis of the Company's assets to fair market value. This will result in additional tax depreciation of fixed assets and tax amortization deduction of goodwill on the current and future tax returns.

At December 31, 2021, the Company has no operating loss carryforwards or tax credit carryforwards.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2021	$ 4,296	$ 28	$ 4,324
2020	—	—	—
2019	N/A	—	—

The Company is included in the consolidated federal income tax return of its parent Anthem, along with other affiliates, as of December 31, 2021. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the IRS due dates.

For the period beginning on the date of the Anthem acquisition, January 23, 2020, the Company filed as a member of the Anthem consolidated federal return and was a member of the IRS Compliance Assurance Process ("CAP") program. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2021, the examination of the 2021 tax year continues to be in process. Prior to the acquisition, the Company was included the consolidated Federal income tax return of WellCare and its includable subsidiaries. As of December 31, 2021 the statute of limitations of the 2018, 2019 and 2020 tax years remain open.

7. Health Insurer Fee

The Company's portion of the annual health insurance industry fee paid during 2020 was paid by WellCare. The health insurer fee, including the income tax impact of the non-deductibility of this fee, was recovered from the State and included in premium income. As part of the agreement to acquire the Company, Anthem agreed to reimburse WellCare for the recovery of the health insurer fee of $8,700, which was included in operating expenses. The 2020 health insurer fee was based on $338,164 of premium written subject to assessment under ACA Section 9010 as of December 31, 2019. The Company had no premiums written subject to assessment under ACA Section 9010 and did not record special surplus funds on the balance sheet as of December 31, 2020 due to the permanent elimination of this assessment, beginning in 2021.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

8. Capital and Surplus

Pursuant to the laws of Nebraska, the Company is required to maintain a minimum surplus equal to the greater of the Company Action Level RBC calculation or $1,500. In addition, the Company is required to maintain certain capital and liquidity levels in conjunction with its BCBSA licensing. At December 31, 2021 and 2020, the Company's capital and surplus exceeded all regulatory requirements.

Under State of Nebraska statutes, the Company is limited in the amount of dividends that can be declared without regulatory approval. The Department must approve any dividend that, together with all dividends declared during the preceding 12 months, exceeds the greater of 10% of statutory surplus existing at the end of the prior calendar year or 100% of adjusted statutory net income earned during the preceding 12 months. The Company may pay $26,329 in dividends during 2022 without prior approval.

The portion of unassigned surplus (deficit) representing cumulative unrealized gains (losses), net of taxes, was ($84) and ($26) at December 31, 2021 and 2020, respectively.

9. Leases

The Company leases office space under a non-cancelable operating lease with a right to renew. There is no escalation clause for the lease. Related lease expense for 2021 and 2020 was $402 and $558, respectively.

Obligations under noncancelable operating leases are not reflected on the balance sheet. At December 31, 2021, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consisted of the following: 2022, $496; 2023, $500; 2024, $70; 2025, $31; 2026, $27 and thereafter, $0.

10. Contingencies

From time to time, the Company is party to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers, generally exclude certain healthcare and other services from coverage under our HMO, PPO, and other plans. The Company is, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential

liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

The Company is involved in pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on the Company's business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

The Company has no other known material contingencies.

11. Employee Benefits

The Company participates in a deferred compensation plan sponsored by Anthem, which covers certain employees once the participant reaches the maximum contribution amount for the Anthem 401(k) Plan (the "401(k) Plan"). The deferred amounts are payable according to the terms and subject to the conditions of the deferred compensation plan. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation plan. The Company has no legal obligation for benefits under this plan.

The Company participates in the 401(k) Plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding, subject to certain limitations. ATH Holding allocates a share of the total costs of the plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

The Company participates in a stock incentive compensation plan, sponsored by Anthem, providing incentive awards to non-employee directors and employees, consisting of Anthem stock options, restricted stock, restricted stock units, stock appreciation rights, performance shares, and performance units. Anthem allocates a share of the total share-based compensation expense of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

During 2021 and 2020, the Company was allocated the following costs or (credits) for these retirement benefits:

	2021	2020
Deferred compensation plan	**$ 7**	$ 4
Defined contribution plan	**543**	260
Stock incentive compensation plan	**508**	507

12. Uninsured Accident and Health Plans

The net gain (loss) from operations and total claim payment volume from administrative services only ("ASO") plans was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
For the year ended December 31, 2021			
Net reimbursement for administrative expenses (including administrative fees) in excess of (less than) actual expenses	**$ (120)**	**$ —**	**$ (120)**
Total net other income or expenses (including interest paid to or received from plans)	**—**	**—**	**—**
Net gain (loss) from operations	**$ (120)**	**$ —**	**$ (120)**
Total claim payment volume	**$ 6,211**	**$ —**	**$ 6,211**

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

13. Health Care Receivables

Pharmaceutical rebate receivables consist of reasonably estimated and billed amounts. Amounts not collected within 90 days of the invoice or confirmation date are nonadmitted. Total admitted and nonadmitted pharmaceutical rebates receivables at December 31 are as follows:

	2021		2020	
	Admitted	**Nonadmitted**	**Admitted**	**Nonadmitted**
Pharmaceutical rebate receivables, reported in health care and other receivables	**$ 110**	**$ 70**	$ 76	$ 10
Total pharmaceutical rebate receivables	**$ 110**	**$ 70**	$ 76	$ 10

Admitted pharmaceutical rebate receivables at December 31, 2021 and 2020, include $110 and $0, respectively, due from IngenioRx, Inc., an affiliated company.

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Total admitted and nonadmitted claim overpayment receivables at December 31 are as follows:

	2021		2020	
	Admitted	**Nonadmitted**	**Admitted**	**Nonadmitted**
Claim overpayment receivables, reported in health care and other receivables	**$ —**	**$ 3,321**	$ —	$ —
Total claim overpayment receivables	**$ —**	**$ 3,321**	$ —	$ —

Provider advances at December 31 are as follows:

	2021		2020	
	Admitted	**Nonadmitted**	**Admitted**	**Nonadmitted**
Provider advances, reported in health care and other receivables	**$ —**	**$ 726**	$ —	$ —
Total provider advances	**$ —**	**$ 726**	$ —	$ —

14. Related Party Transactions

Effective January 23, 2020 and approved by the Department on March 18, 2020, the Company entered into administrative services agreements with its affiliated companies known as the Anthem Inc. Master Services Agreement ("MSA") and the FMV Services Attachment. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, pharmacy benefits management services, consulting services, rent, utilities, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics. Under the FMV Attachment, the costs and expenses related to certain care management and other services are allocated to or allocated by the Company in an amount equal to the fair market value of the services provided. These costs are allocated based on various utilization statistics.

The Company’s management services agreement with Comprehensive Health Management, Inc. (“CHMI”) was terminated upon purchase of the Company by Anthem. In connection with the purchase agreement, the Company entered into a transition services agreement (“TSA”) with CHMI for services necessary for the Company to conduct its activities. The TSA was effective for six months and included two 3-month extensions. The TSA fees for continuing services were $22.00 per member per month for Medicaid.

Net payments to affiliated companies pursuant to the above administrative service agreements were $34,010 and $18,575 in 2021 and 2020, respectively, and are included in operating expenses and claims and claims adjustment expenses in the statutory statements of operations.

At December 31, 2021 and 2020, the Company reported no amounts due from affiliates. At December 31, 2021 and 2020, the Company reported $3,220 and $3,992 due to affiliates, respectively. The payable balances represent intercompany transactions that are settled in accordance with the settlement terms of the intercompany agreement.

On October 1, 2020, the Company issued 5.263 of additional shares of common stock at par value ($1.00) to BCBSNE and the Company received a capital contribution from BCBSNE of $6,760.

On September 30, 2020, the Company's parent company, APHC, authorized and paid a capital contribution to the Company in the amount of $2,500.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

The Board of Directors of the Company declared an ordinary dividend in the amount of $15,000 on April 16, 2020. The Company paid the dividend to its parent company, ATH Holding, on May 26, 2020.

During the first quarter of 2020 and in connection with the Company's sale to Anthem, the Company received a non-cash capital contribution of $1,039 from its prior parent, WCMG, which consisted of furniture and equipment.

Community Care Health Plan of Nebraska, Inc.

Notes to Financial Statements - Statutory Basis (continued)

(Dollars In Thousands)

15. Reconciliation to Statutory Annual Statement and Subsequent Events

Subsequent to the issuance of the Annual Statements, but prior to the issuance of the financial statements, the Company identified adjustments needed to various items in both 2021 and 2020. Related adjustments were made in the accompanying statutory basis financial statements. The table following reconciles capital and surplus and net income as reported in the Annual Statements to the accompanying statutory basis financial statements:

	2021	2020
Total net income as reported in the Annual Statement	$ 28,601	$ 5,101
Impact to premium income	(3,070)	3,070
Impact to operating expenses	194	(194)
Impact to federal income taxes (benefits)	604	(604)
Total net income as reported in the accompanying statutory financial statements	$ 26,329	$ 7,373
Total capital and surplus as reported in the Annual Statement	$ 92,017	$ 67,462
Impact to net income noted above	—	2,272
Impact to nonadmitted assets	(1,870)	—
Total capital and surplus as reported in the accompanying statutory financial statements	$ 90,147	$ 69,734
Total admitted assets as reported in the Annual Statement	$ 259,007	$ 179,953
Impact to current federal tax recoverable	—	(122)
Impact to deferred tax asset	(1,870)	—
Total admitted assets as reported in the accompanying statutory financial statements	$ 257,137	$ 179,831
Total liabilities as reported in the Annual Statement	$ 166,990	$ 112,491
Impact to aggregate policy reserves	—	(3,070)
Impact to accounts payable and accrued expenses	—	194
Impact to federal income tax payable	—	482
Total liabilities as reported in the accompanying statutory financial statements	$ 166,990	$ 110,097

Management of the Company has evaluated all other events occurring after December 31, 2021 through April 8, 2022, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no events that require recognition or disclosure in the financial statements through the report date.

Supplementary Information - Statutory Basis

Ernst & Young LLP
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Building a better working world

Report of Independent Auditors on Supplementary Information

Board of Directors
Community Care Health Plan of Nebraska, Inc.

We have audited the statutory basis financial statements of Community Care Health Plan of Nebraska, Inc. as of and for the years ended December 31, 2021 and 2020, and have issued our report thereon dated April 8, 2022, which contained an adverse opinion with respect to conformity with U.S. generally accepted accounting principles and an unmodified opinion with respect to conformity with accounting practices prescribed or permitted by the Nebraska Department of Insurance on those financial statements. Our audits were performed for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the statutory basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Restriction on Use

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

April 8, 2022

Community Care Health Plan of Nebraska, Inc.

Summary Investment Schedule - Statutory Basis

(Dollars In Thousands)

December 31, 2021

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	Amount	Percentage of Gross Investment Holdings	Amount	Securities Lending Reinvested Collateral Amount	Total	Percentage of Total Admitted Invested Assets
Long-Term Bonds:						
U.S. governments	$ 20,162	8.9 %	$ 20,162	$ —	$ 20,162	8.9 %
U.S. political subdivisions of states, territories, and possessions, guaranteed	2,880	1.3	2,880	—	2,880	1.3
U.S. special revenue and special assessment obligations, etc. non-guaranteed	6,438	2.8	6,438	—	6,438	2.8
Industrial and miscellaneous	135,094	59.5	135,094	—	135,094	59.5
SVO identified funds	44,725	19.7	44,725	—	44,725	19.7
Total long-term bonds	209,299	92.2	209,299	—	209,299	92.2
Cash, cash equivalents and short-term investments:						
Cash	11,801	5.2	11,801	—	11,801	5.2
Cash equivalents	6,000	2.6	6,000	—	6,000	2.6
Total cash, cash equivalents and short-term investments	17,801	7.8	17,801	—	17,801	7.8
Total invested assets	$ 227,100	100.0 %	$ 227,100	$ —	$ 227,100	100.0 %

Community Care Health Plan of Nebraska, Inc.

Investment Risks Interrogatories - Statutory Basis

(Dollars In Thousands)

December 31, 2021

1. The Company's total admitted assets as reported on Page 2 of the Annual Statement are: $259,007

2. Ten largest exposures to a single issuer/borrower/investment:

	Investment	Description of Exposure	Amount	Percentage of Total Admitted Assets
2.01	Charter Communications Inc	Bond	$ 3,858	1.5 %
2.02	Best Buy Co Inc	Bond	3,430	1.3
2.03	RR Ltd	Bond	3,400	1.3
2.04	The Goldman Sachs Group Inc	Bond	3,294	1.3
2.05	Australia & New Zealand Banking	Bond	3,115	1.2
2.06	Vistra Corp	Bond	3,088	1.2
2.07	Illinois Finance Authority	Bond	2,796	1.1
2.08	Bank of America Corp	Bond	2,614	1.0
2.09	TTWF LP	Bond	2,457	0.9
2.10	Triton International Ltd	Bond	2,422	0.9

3. The Company's total admitted assets held in bonds by NAIC designation are:

	Bonds	Amount	Percentage of Total Admitted Assets
3.01	NAIC - 1	$ 111,361	43.0 %
3.02	NAIC - 2	88,874	34.3
3.03	NAIC - 3	4,674	1.8
3.04	NAIC - 4	4,390	1.7
3.05	NAIC - 5	—	—
3.06	NAIC - 6	—	—

The Company has no investments in preferred stock at December 31, 2021.

4. Assets held in foreign investments:

   4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?

   Yes [ ] No [X]

Community Care Health Plan of Nebraska, Inc.

Investment Risks Interrogatories - Statutory Basis (continued)

(Dollars In Thousands)

		Amount	Percentage of Total Admitted Assets
4.02	Total admitted assets held in foreign investments	$ 22,775	8.8 %
4.03	Foreign-currency-denominated investments	—	—
4.04	Insurance liabilities denominated in that same foreign currency	—	—

5. Aggregate foreign investment exposure categorized by NAIC Sovereign rating:

		Amount	Percentage of Total Admitted Assets
5.01	Countries rated NAIC - 1	$ 22,775	8.8 %
5.02	Countries rated NAIC - 2	—	—
5.03	Countries rated NAIC - 3 or below	—	—

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

		Amount	Percentage of Total Admitted Assets
	Countries rated NAIC - 1		
6.01	Country: United Kingdom	$ 3,593	1.4 %
6.02	Country: Norway	2,905	1.1
	Countries rated NAIC - 2		
6.03	Country:	—	—
6.04	Country:	—	—
	Countries rated NAIC - 3 or below		
6.05	Country:	—	—
6.06	Country:	—	—

7. The Company has no unhedged foreign currency exposure.

8. The Company has no unhedged foreign currency exposure.

9. The Company has no unhedged foreign currency exposure.

Community Care Health Plan of Nebraska, Inc.

Investment Risks Interrogatories - Statutory Basis (continued)

(Dollars In Thousands)

10. Ten largest non-sovereign (i.e.non-governmental) foreign issues:

	Issuer	NAIC Rating	Amount	Percentage of Total Admitted Assets
10.01	Australia & New Zealand Banking	1	$ 3,115	1.2 %
10.02	DNB ASA	1	1,940	0.7
10.03	Cooperatieve Rabobank UA	1	1,803	0.7
10.04	Triton International Ltd	2	1,699	0.7
10.05	Credit Agricole Group	1	1,566	0.6
10.06	Lloyds Banking Group PLC	1	1,536	0.6
10.07	Credit Suisse Group AG	2	1,530	0.6
10.08	Golub Capital Partners CLO Ltd	1	1,425	0.6
10.09	Nippon Telegraph & Telephone Corporation	1	1,400	0.5
10.10	Skandinaviska Enskilda Banken	1	1,345	0.5

11. Assets held in Canadian investments are less than 2.5% of the total admitted assets.

12. Assets held in investments with contractual sales restrictions are less than 2.5% of the total admitted assets.

13. Assets held in equity interests are less than 2.5% of total admitted assets.

14. Assets held in unaffiliated, privately placed equities are less than 2.5% of total admitted assets.

	Ten Largest Fund Managers	Total Invested	Diversified	Non-Diversified
14.06	BlackRock Inc	$ 25,983	$ 25,983	$ —
14.07	State Street Corp	8,824	8,824	—
14.08	The Vanguard Group Inc	7,719	7,719	—
14.09	Deutsche Bank AG	6,000	6,000	—
14.10	Van Eck Associates Corp	2,200	2,200	—

15. Investments in general partnership interests are less than 2.5% of the total admitted assets.

16. The Company has no investments in mortgage loans.

17. The Company has no investments in mortgage loans.

18. The Company has no investments in real estate.

19. The Company has no potential exposure for mezzanine real estate loans.

Community Care Health Plan of Nebraska, Inc.

Investment Risks Interrogatories - Statutory Basis (continued)

(Dollars In Thousands)

20. The Company has no assets subject to the following types of agreements: securities lending, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements or dollar reverse repurchase agreements.

21. The Company held no admitted assets for warrants not attached to other financial instruments, options, caps and floors.

22. The Company held no admitted assets with potential exposure for collars, swaps and forwards.

23. The Company held no admitted assets with potential exposure for futures contracts.

Community Care Health Plan of Nebraska, Inc.

Note to Supplementary Information - Statutory Basis

(Dollars In Thousands)

Year ended December 31, 2021

Note-Basis of Presentation

The accompanying supplemental schedules present selected statutory financial information as of December 31, 2021 and for the year then ended for purposes of complying with the National Association of Insurance Commissioners' *Annual Statement Instructions* and the National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual,* and agrees to or is included in the amounts reported in the Community Care Health Plan of Nebraska, Inc.'s 2021 Annual Statement as filed with the Nebraska Department of Insurance.

The Company has not identified any reinsurance contracts entered into, renewed or amended on or after January 1, 1996 that would require disclosure in the supplemental schedule of life and health reinsurance disclosures as required under SSAP No. 61R, *Life, Deposit-Type and Accident and Health Reinsurance*.

Captions or amounts that are not applicable have been omitted.

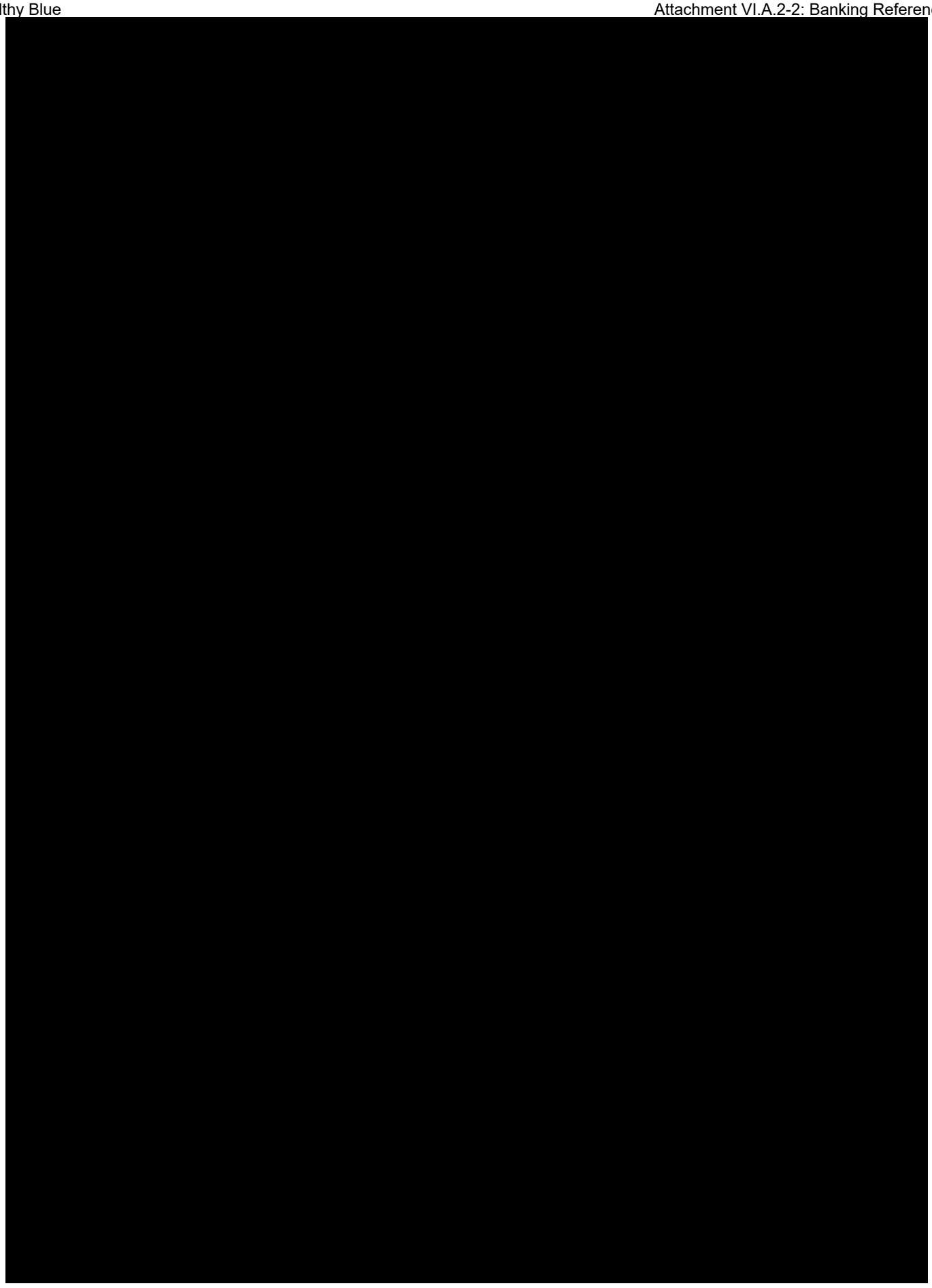
CALLED TO CARE - Jodi Payne, Community Relations Representative/Interim Marketing/Community Relations Manager

Born and raised in Nebraska, I am most passionate about understanding members' needs and assisting in closing identified gaps in care. In my role at Healthy Blue, I have participated in numerous food and diaper distribution events, health fairs, and other events which have assisted thousands of families to have better access to food and essential supplies.

CALLED TO CARE: My brother, who worked for an employer that did not provide affordable health insurance coverage, passed at the age of 35 while seeking medical attention for his condition. His lack of insurance prevented him from receiving the diagnostic services and medical procedures that could have potentially saved his life. My brother's experience reminds me daily of why I am committed to the work that I do at Healthy Blue. I am invested in the health and lives of our Medicaid members and their families and I strive to work with humility and compassion while serving them.

Attachment VI.A.2-2: Banking Reference

Healthy Blue



Empowering Providers

Healthy Blue was recognized by LifeBridge Nebraska as a “Champion for Physician Wellness” as we continue to support the health and well-being of health care professionals.

Attachment VI.A.8-1: Letters of Support

Healthy Blue

Attachment VI.A.8-1: Letters of Support

Attachment VI.A.8-1 includes the following:

- VI.A.8-1a: Blue Cross and Blue Shield of Nebraska
- VI.A.8-1b: Catholic Charites of the Archdiocese of Omaha
- VI.A.8-1c: Go Physical Therapy
- VI.A.8-1d: Mid-America Council, Boy Scouts of America
- VI.A.8-1e: Norfolk Area Pride
- VI.A.8-1f: Norfolk Sixpence
- VI.A.8-1g: Obstetricians & Gynecologists, P.C.
- VI.A.8-1h: Partnership 4 Kids
- VI.A.8-1i: Project Homeless Connect Norfolk (PHCN)
- VI.A.8-1j: The Zone Afterschool Program
- VI.A.8-1k: Together
- VI.A.8-1l: United Way of Western Nebraska
- VI.A.8-1m: Whispering Roots
- VI.A.8-e1n: YWCA Lincoln

BlueCross BlueShield Nebraska

P.O. Box 3248
1919 Aksarben Drive

Omaha, NE 68180-0001
nebraskablue.com

May 16, 2022

Robert B. Rhodes, MD, FAAFP
RVP II/President
Healthy Blue Nebraska
8055 “O” Street | Suite 300
Lincoln, NE 68510

Dear Bob:

We want to take this opportunity to voice our support of Healthy Blue and its continued administration of Nebraska’s Medicaid program. Healthy Blue, a partnership between Anthem, Inc. and Blue Cross and Blue Shield of Nebraska, brings together Anthem’s extensive experience in delivering best-in-class Medicaid programs with BCBSNE’s 80+ years of providing peace of mind and security to members across the state.

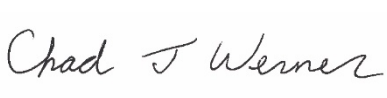
Ensuring care access and equity is fundamental to the health and well-being of our communities. The benefits and programs offered by Healthy Blue are extensive, and address far more than important coverage for needed medical care. Whether it’s transportation to appointments, incentives to live a healthy lifestyle, extra help for new moms or support and guidance through complex health conditions, the Healthy Blue program demonstrates a commitment to the thousands of Nebraskans who depend upon the Medicaid program.

Anthem, Inc. has been a strong and valued partner and shares our commitment to building healthier, stronger communities across Nebraska. The structure they have built, with its focus on patient outcomes and efficient and effective delivery of services, remains strong. We are confident in their ability to continue to serve Nebraska’s Medicaid population.

Please feel free to reach out to any of us if you have questions or need additional information.

Sincerely,

Steven H. Grandfield
President and CEO



Chad Werner
Chief Financial Officer

Josette Gordon-Simet, M.D.
Chief Medical Officer

CATHOLIC CHARITIES of Omaha

Behavioral Health Services
Domestic Violence Services
Emergency and Supportive Food
Family Strengthening Services
Immigration Legal Services
Microbusiness and Asset Development Program

Dear Robert Rhodes,

My name is Mikaela Schuele and I am the Director of Emergency and Supportive Food Services for Catholic Charities. I write on behalf of Catholic Charities of the Archdiocese of Omaha Nebraska in support of Healthy Blue.

In my work I oversee three food pantries, home delivery services, and a mobile pantry program. In the year 2021, our Catholic Charities Pantry Program distributed 2.8 million pounds of food to 222,000 individuals. A program this large often yields attention from service providers, hoping to use our platform to acquire clients. I have turned away many organizations wanting set up a booth at our pantry to speak with clients, as it is our policy that Catholic Charities cannot promote one provider over another. We have found that many providers see our services as a location where vulnerable individuals go for help. Therefore, such providers prey on the vulnerability of our community members by convincing them to sign up for their services. These providers deliver empty promises of benefits, and leave our community members more confused and isolated than ever.

On a brisk fall afternoon, I met with Bianca Zuniga, a Healthy Blue Community Relations Representative. I approached the meeting with a bias view, assuming Bianca's intentions were going to mirror that of the other providers I had spoken to and turned away. To my surprise, Bianca was very receptive to my notion "we cannot promote one provider over another." Bianca's professional response stated that it is not Healthy Blue's intention to promote their services, but to educate our community members on all services available to them through all providers, so they may choose the plan that best fits their needs. Additionally, Bianca expressed interest in supporting Catholic Charities through sponsoring Irish Fest, Catholic Charities biggest fundraiser of the year. Humbled by our conversation, I agreed to continue the conversation with Healthy Blue sponsoring Catholic Charities and educating our community members.

As the months continued, I became more aware of Healthy Blue's presence in the community and the good works of the organization. Healthy Blue began making referrals to Catholic Charities collaborative home delivery program with Whispering Roots and Together Inc. Additionally, Healthy Blue expressed interest in sponsoring an event with Whispering Roots and Catholic Charities to provide diapers, produce, dairy, meat, and eggs to the Omaha Tribe in Macy and Walthill, NE – desolate and dying towns frequented monthly by Catholic Charities live saving mobile pantry program. To my surprise, Healthy Blue not only donated nourishing foods, but also joined the mobile pantry distribution to volunteer and attain frontline experience. Healthy Blue volunteers witnessed as tears sprung into the tribal member's eyes when they witnessed the delicacies of milk, eggs, and fresh meats loaded into their vehicles.

After an extremely positive and humbling experience in Macy and Walthill, Healthy Blue committed to providing $2,000 and one volunteer monthly to Whispering Roots and Catholic Charities collaborative mobile pantry for the Omaha Tribe. Because of Healthy Blue, we are able to consistently provide the Indian Reservations with milk, eggs, and meat. This is not only a blessing, but also life saving for the impoverished families, living in desolate homes without resources.

Healthy Blue is not just a provider of Healthcare, Healthy Blue is a provider of Hope, and an organization Catholic Charities is proud to be partnered with and sponsored by.

Mikaela Schuele

Mikaela Schuele
Director, Emergency and Supportive Food Services, Catholic Charities

Catholic Charities of the Archdiocese of Omaha
Juan Diego Center
5211 South 31st Street, Omaha, NE 68107 • www.ccomaha.org
Emergency and Supportive Food Services 402.731.5413 • Family Strengthening Services 402.829.9253
Immigration Legal Services 402.939.4615 • Microbusiness Training Program 402.939.4637
Domestic Violence Crisis Hotline • 402.558.5700
A United Way Agency • Member of Catholic Charities USA • Accredited by Council on Accreditation

GO Physical Therapy

June 17, 2022

Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Re: Letter of Recommendation for Healthy Blue

To Whom It May Concern:

I am writing this letter to recommend that Healthy Blue of Nebraska continue to be one of the three Medicaid companies that comprise Heritage Health. As is stands, the vision and outstanding leadership of Robert Rhodes, MD, President of Healthy Blue, Deborah Esser, MD, Chief Medical Officer, and Heather Leschinsky Director Network Management and Interim State Director of Operations, have been exemplary. They have met with us as frequently, up to two times per month, and most recently one time per month, diligently working to continue to improve access for patients for physical therapy in the state of Nebraska. Dr. Rhodes is a visionary. Throughout our meetings, has been willing to make substantial changes to the company that pre-authorizes therapy sessions. We are pleased with the results and the willingness of leadership at Healthy Blue to work with therapists and address our concerns.

Patient access to therapy care continues to be a major issue in Nebraska that is hindered by an extreme administrative burden. While Healthy Blue's therapy pre-authorization process is not ideal, we are excited and encouraged by the upcoming changes to this process, particularly in terms of its efficiency.

Please accept this letter of recommendation for Healthy Blue and contact us with any further questions or concerns.

Sincerely,

Brian Brunken PT, MSPT, OCS

Brian Brunken, PT, MSPT
Board-Certified Clinical Specialist in Orthopedics
President

18101 R Plaza, Suite 106 • Omaha, Nebraska 68135 • Phone: (402) 933-8333 • Fax: (402) 933-4755 • www.gophysicaltherapy.net

BOY SCOUTS OF AMERICA®
MID-AMERICA COUNCIL

March 10, 2022

To whom it may concern:

The Mid-America Council, Boy Scouts of America inspires youth and adults in 58 counties in Nebraska and Southwest Iowa. We currently have 8,000 youth and their families involved in the Scouting program. We excel in youth leadership programs, outdoor education, community service, charter building and fun! Our organization foundation is based on volunteers and community collaborations.

Mid-America Council knows Healthy Blue Nebraska, is committed to communities across the state and have demonstrated this by their actions. Whether it is Community Relations Rep being present to assist families on navigating their benefits including Value Added Benefits for adults and youth, the Norfolk Welcome Room space for members and partners including the Eagle Scout Review, partnering in food distributions, or supporting programs which help improve the quality of life for families in Nebraska. We continue to appreciate the cooperative positive partnership provided by the dedicated members in the local area.

We're proud of the extraordinary work they have done, and will continue to do, to help improve the quality of life by placing attention to the health care needs.

Yours in Scouting,

Chris Mehaffey, CEO
Mid-America Council

Durham Scout Center
12401 West Maple Road
Omaha, NE 68164
www.mac-bsa.org

Prepared. For Life.™

NORFOLK AREA PRIDE

PO BOX 1070, NORFOLK, NE 68702 | NORFOLKAREAPRIDE@GMAIL.COM | NORFOLKAREAPRIDE.ORG

Dr. Robert Rhodes, MD RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Robert Rhodes,

I write on behalf of Norfolk Area Pride in support of Healthy Blue Nebraska serving the Medicaid population in Nebraska. We strongly support Healthy Blue Nebraska and their commitment to improving quality of life.

Healthy Blue Nebraska has formed a meaningful partnership with Norfolk Area Pride to help us further our mission to provide services, community education, safety, awareness, and support for LGBTQ+ individuals in Northeast Nebraska. Healthy Blue Nebraska has gone above and beyond to support our organization's work by allowing us to use their Norfolk Welcome Room for peer support meetings and board meetings; providing healthy beverages and snacks for our event volunteers; donating funds to bring inclusion education to our community; and donating healthy beverages for our Holiday peer support gathering. Mindy Spray, Community Relations Rep, has gone out of her way to communicate with me and jumps on every opportunity to support our organization.

As a community member, I have seen Healthy Blue Nebraska's overall commitment to our community. From donating to improve our public transit, to involvement in the Norfolk Area Diversity Council; I strongly believe in Healthy Blue Nebraska's impact.

We look forward to working with Healthy Blue Nebraska to improve our community for many years to come.

Sincerely,

MBailey

Mo Bailey
President
402-640-8515

NORFOLK AREA PRIDE IS A NON-PROFIT ORGANIZATION THAT PROVIDES SERVICES, COMMUNITY EDUCATION, SAFETY, AWARENESS AND SUPPORT FOR LGBTQ+ INDIVIDUALS IN NORTHEAST NEBRASKA.

LITTLE PANTHERS
PRESCHOOL
NOTHING PREVENTS SUCCESS!

March 11, 2022

Dr. Robert Rhodes, MD RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Robert Rhodes,

With the State of Nebraska planning to release a Managed Care Health Plan Request for Proposal (RFP) in the coming months, we are pleased to send this letter in support of Healthy Blue Nebraska continuing care for the Medicaid population.

Representing one of Heritage Health plan options for Medicaid members, Healthy Blue Nebraska has provided coverage to thousands of Medicaid beneficiaries in the State of Nebraska. Healthy Blue Nebraska has been committed to its members and communities in which they live by providing services and establishing partnerships throughout the state.

We are just one of the many programs in the State of Nebraska that Healthy Blue Nebraska has assisted and partnered. Healthy Blue Nebraska representatives have remained in contact with our program staff and assisted our families by having food drives, supporting our Norfolk Sixpence diaper drive, coming to family socializations to share Medicaid information, providing nutritious fruits to families attending socializations, allowing us to use their community room at their office, providing staff with help for families navigating their benefit portal online, hosting community baby showers in which our families have attended, and been available via phone or in-person for families to contact in regards to questions

In addition to collaborating with community-based organizations and providers, we are impressed with the many ways Healthy Blue Nebraska continues to offer additional benefits and support for their members based on their needs. Healthy Blue Nebraska offers benefits outside of health insurance that promote health and assist families, such as: programs for prenatal mothers, transportation, swimming lessons, summer camps, reading program, 24/7 crisis line, community baby showers, healthy rewards program, GED testing, college assistance, welcome rooms, and several other value added benefits.

Norfolk Sixpence offers our full support of Healthy Blue Nebraska as one of the Medicaid health plan choices serving our communities. We look forward to continuing to serve the community and improve healthcare for families in our area alongside Healthy Blue Nebraska.

Sincerely,

Heather Hirsch
Sixpence Family Facilitator

Kerstin Ditter
Sixpence Family Facilitator

Rachel Bauer
Sixpence Family Facilitator

Certified by American Board of Obstetrics & Gynecology / Fellows of American College of Obstetrics & Gynecologists
SRC - Master Surgeons in Minimally Invasive Gynecology

Obstetricians & Gynecologists, P.C.
Obstetrics · Gynecology · Infertility

Todd A. Pankratz, M.D.
Jill L. Fish, M.D.
Tyler J. Adam, M.D.
Katie Thompson, M.D.
Andrea Curtis, A.P.R.N.
Jesse Kirkpatrick, A.P.R.N.
Lindsay Van Pelt, A.P.R.N.
Holly Eckhart, C.N.M.
Katelyn Mazuch, C.N.M.
Brandy Rogers, C.N.M.
Melissa Wiles, L.M.H.P.

To Whom It May Concern:

As Healthy Blue Nebraska heads into their upcoming RFP with the State of Nebraska, I would like to offer my support in favor of their ongoing service in our community. Our medical practice has had a very positive relationship with Healthy Blue over the course of this past year.

Our representative with Healthy Blue is always a great help. She is prompt on answering emails and is very consistent with monthly meetings with our coding staff to answer all questions and concerns. She takes the initiative to send HB updates and information from their website that pertains to issues we have discussed with her. HB's regular Town Hall meetings have been a great source of information as well.

The Healthy Blue staff en masse is accomplished and helpful. When we reach out to HB we are given the help needed or directed to the appropriate contact. This has saved us much wasted telephone time which is invaluable for a busy practice such as ours. Claims are handled with efficiency and accuracy.

In addition, Dr. Robert Rhodes has been a valuable asset to Healthy Blue as an involved and easily accessible leader. When we experienced problems at the beginning of our relationship, Dr. Rhodes personally came to our clinic. He listened to our concerns and ensured that they were dealt with and resolved to our mutual satisfaction.

Sincerely,

Todd A. Pankratz, MD

Owner/Physician

2115 N Kansas Ave, Suite 204 • Hastings, NE 68901 • p 402-463-6793 • f 402-463-6894 • after hours 402-462-8566
1010 Diers Avenue, Suite 4B • Grand Island, NE 68803 • p 308-381-1490 • www.obgynnebraska.com

1004 Farnam Street, Suite 200 | Omaha, NE 68102
P: 402-930-3000 | F: 402-930-3006 | www.p4k.org

Dr. Robert Rhodes, MD
RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Robert Rhodes,

On behalf of Partnership 4 Kids, I am pleased to send this letter in support of Healthy Blue Nebraska. I applaud the wonderful health initiatives they have implemented for families throughout the Omaha metro, especially those that have directly supported the young people that Partnership 4 Kids serves.

For 33 years, Partnership 4 Kids has been providing programming and wrap-around services for low-income and marginalized youth in Northeast and Southeast Omaha. Partnership 4 Kids annually positions hundreds of young people to overcome systemic barriers, household challenges, and trauma-induced behaviors by engaging them in their academics, exploration of career pathways and planning for a future that is financially stable and provides self-satisfaction.

Healthy Blue-Nebraska, has provided annual increases in their financial contributions to our agency's Adopt-A-Student campaign over the past three years, enabling Partnership 4 Kids to provide critical care and programming interventions for more students during the height of the pandemic. They have also provided in-kind support and volunteer man-power at the Omaha Marathon, an event for which Partnership 4 Kids is the benefitting charity.

Healthy Blue-Nebraska (Omaha) is an excellent community partner, building authentic relationships with Omaha non-profits like P4K so that together we can better serve shared goals to make Omaha a healthier and more pleasant community in which to live.

Partnership 4 Kids fully supports the work of Healthy Blue Nebraska and looks forward to our continued partnership on future ventures that serve our community.

Sincerely,

Cheryl Murray, Director of Development
Partnership 4 Kids

PROJECT HOMELESS CONNECT™

February 18, 2022

Dr. Robert Rhodes, MD RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Robert Rhodes,

Project Homeless Connect Norfolk (PHCN) is pleased to provide this letter of support for Healthy Blue Nebraska. PHCN is a one-day, one-stop event where individuals in need can access a multitude of service providers all under one roof for free. What normally would take months to accomplish can be completed in one day. From medical and dental providers to mental health practitioners, to housing assistance programs and health insurance assistance, our goal is to help individuals get the resources and services necessary to build their life again and move in a positive direction. October 8th, 2021 marked the 5th Annual PHCN, and nearly 550 guests were served in that single day. Healthy Blue Nebraska has participated as an on-site service provider during the event, as well as financially supporting this event for the past several years.

PHCN continues to see an increase in the number of homeless and near homeless individuals in Norfolk and Northeast Nebraska. With the financial support of Healthy Blue Nebraska, PHCN was able to provide additional assistance to the homeless. Without the financial support of businesses such as Healthy Blue Nebraska, PHCN would not be able to fulfil its mission of responding to the community need of helping the homeless and near homeless.

We are grateful for Healthy Blue Nebraska's commitment to ensure that Norfolk and Northeast Nebraska's homeless have access to immediate lifesaving services. Unlike other Nebraska Medicaid Managed Care plans, Healthy Blue Nebraska has recognized the need for PHCN and the value that this event brings to hundreds of lives each year. Healthy Blue Nebraska is an absolute joy to work with, and their passion for helping the underprivileged have access to health coverage is like none other. PHCN is looking forward to a continued partnership with Healthy Blue Nebraska and its lasting impact on our community.

Sincerely,

Lacy Kimes

Lacy Kimes, PHCN Coordinator

~Project Homeless Connect Norfolk...A Community Response to a Community Problem~

tel 877-379-3798 601 E. Norfolk Ave., Norfolk, NE 68701 fax 402-379-2626

www.projecthomelessconnectnorfolk.org

THE ZONE
AFTERSCHOOL PROGRAM

Dr. Robert Rhodes, MD RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Robert Rhodes,

The Zone Afterschool Program is pleased to provide this letter of support for Healthy Blue. Healthy Blue has partnered with The Zone Afterschool Program in many beneficial ways. The Zone is a safe and structured place for Norfolk area youth in 7th-12th grade to attend afterschool. Because 75% of our youth qualify for free and reduced lunch, there is a need for extra groceries and food to be provided for our families. The majority of our youth come form lower income families, and do not always have access to necessary resources.

In an effort to help relieve some of the financial stress of our families, Healthy Blue has held two food drives for The Zone. They provided each Zone student with 3 bags full of fresh fruits, veggies, and non-perishable items to take home. Because of these food drives, Healthy Blue helped aid over 40 families in our organization. Along with providing food, they also provided a pumpkin for each student to be able to take home and carve with their family. The Zone encourages family-oriented activities and our families may not have had the means to do an activity like this otherwise.

Healthy Blue has done a wonderful job at collaboration and finding out what our students and families specific needs are. Healthy Blue has offered to bring our students in to their meeting room and do a hands-on healthy baking activity with them along with an interactive art activity. They have also offered to come and teach our students about wellness.

The Zone is grateful for their partnership with Healthy Blue and sees them as a vital and integral part of the Norfolk Area Community.

Sincerely,

Alexis Huisman

Executive Director

Together
Collaborating to End Homelessness

Dear Dr. Robert Rhodes,

Together, a collaborative partner of Healthy Blue, is proud to submit a letter of support for Healthy Blue Nebraska. As Director of Community Partnerships for Together I attest to the importance of Healthy Blue in serving our community which experiences housing and food insecurity due to poverty.

Healthy Blue Nebraska has been a valuable partner in helping us educate young mothers in cooking programs, providing nutrition education programming, and a strong partner in making a healthier neighborhood. We currently work with Healthy Blue to develop a much needed outside wellness area to promote physical activity and exercise as well as neighborhood togetherness. This is so essential as many of our community participants lack physical activity and do not feel safe to go outside. With Healthy Blue, we are changing our neighborhood and the health of our community members.

Together is a collaborative nonprofit committed to ending homelessness and hunger through self-sufficiency programming. We have over 50 collaborative partners across the nonprofit, private and public sectors. Of all our partners, Healthy Blue is continuously there not just for programming but to investigate innovative ideas that lift children and households out of poverty. I am proud to consider Healthy Blue a partner and strongly support Healthy Blue Nebraska's future growth because it will help many families in need.

Respectfully

Craig Howell
Director of Community Partnerships
Together
Chowell@togetheromaha.org
402-669-9315

Best Practices

812 S 24th Street · Omaha, Nebraska 68108 · 402.345.8047 · TogetherOmaha.org

United Way
of Western Nebraska

Alliance Office
P.O. Box 617
723 Flack Ave
Alliance, NE 69301
Scottsbluff Office
1517 Broadway, Suite 106
Scottsbluff, NE 69361

March 3, 2022

Dr. Robert Rhodes
RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Rhodes,

I am writing this letter to demonstrate the strong community partner Healthy Blue Nebraska is in the communities we serve.

I have been the Director of United Way of Western Nebraska serving Box Butte and Dawes Counties since 2015 and in January, I accepted the position of Executive Director of United Way of Western Nebraska. I have had the privilege to work with the local and regional Healthy Blue Nebraska staff on various projects, including United Way's Fighting Hunger in Our Community.

Healthy Blue Nebraska is a key stakeholder partnering with United Way of Western Nebraska's Fighting Hunger in our Community which provides fresh fruits and vegetables, non-perishable items, meat, cheese, eggs and dairy among other food items directly to families experiencing food insecurity in Western Nebraska. Healthy Blue Nebraska partnered with United Way in Box Butte County in October of 2021 where we served 75 families and distributed directly to low-income families and seniors. Most recently they have assisted both financially and through volunteerism to provide food directly to 100 families in Chadron on February 25, 2022 and an additional 75 families are set to be assisted in Crawford on March 15. Each household receives 3 large reusable bags of food. One bag containing fresh produce such as carrots, lettuce, oranges and bananas. One was filled with eggs, milk, meat and cheese and another bag with spaghetti sauce, noodles, flour tortillas and other items to allow the families to make several complete meals from the items they received. One recipient from Chadron remarked, that when they received the food bags they were uncertain how they would make it to the end of the month, "The program is just wonderful!"

Healthy Blue Nebraska has made a commitment to partner with United Way in the local community and directly address food insecurity. The staff at Healthy Blue Nebraska readily volunteer their time to assist with important community impact work. Together in 2022 we have already served 175 families by the end of March with 525 bags of food and are on track to serve close to 600 families directly (1800 bags of food) with the Fighting Hunger in Our Communities partnership. We are grateful to have Healthy Blue Nebraska in the communities we serve.

Please feel free to contact me at 308-763-8031 or kbenzel@uwwn.org with any questions or to discuss additional information.

Best,

Karen Benzel
Executive Director

WHISPERING ROOTS

Growing. Feeding. Educating.

March 7, 2022

Dr. Robert Rhodes, MD RVP II/President
Healthy Blue Nebraska
8055 O Street, Suite 300
Lincoln, NE 68510

Dear Dr. Rhodes,

Whispering Roots is extremely pleased to provide this letter of support for Healthy Blue Nebraska. Whispering Roots is a nonprofit organization that is dedicated to bringing fresh healthy food, nutrition education, food logistics support and economic development to the most impoverished communities. In 2021, Whispering Roots aggregated, purchased, and distributed more than 1.8 million pounds of healthy emergency food into urban, rural and native communities in our region who face food insecurity. In addition, we provide nutrition and culinary training for children, families and seniors living in poverty.

With the assistance and financial support of Healthy Blue, Whispering Roots has been able to host multiple community food distributions with a focus on providing fresh healthy produce, protein, milk, and dairy products to those most in need. These food distributions have been a lifeline for communities that suffered through the worst of the COVID19 pandemic as well as for communities that continue to face food insecurity and the highest poverty levels. In addition, Healthy Blue is providing a refrigerated delivery van to help Whispering Roots expand the distance we can provide fresh food which requires our organization to maintain the cold chain for food safety. Healthy Blue goes above and beyond other organizations in their space by becoming actively involved in the communities where they maintain a presence. We could not do our work and fulfill our mission without the collaboration and support of our partners at Healthy Blue.

We are extremely grateful for Healthy Blue's commitment to improving the health of our clients and increasing the availability of healthy nutritious food in communities of color, native communities, poverty-stricken communities, and rural communities. We look forward to our future collaborations and the positive impact they will have on the people we serve.

Sincerely,

Gregory Fripp
Founder and Chief Executive Officer
Whispering Roots, Inc
(402) 321-7228

4104 S. 90th Street, Omaha NE 68127
www.whisperingroots.org

eliminating racism
empowering women
ywca

February 28, 2022

Halea Pacula
Director of Family & Community Engagement
YWCA Lincoln
1701 S 17th St. Suite 2E
Lincoln, NE 68502

Dear Dr. Robert Rhodes,

YWCA Lincoln is a non-profit organization that is dedicated to eliminating racism and empowering women and promoting peace, justice, freedom and dignity for all. Our three signature platforms that drive our organization are racial justice and civil rights, empowerment and economic advancement of women and girls and health and safety of women and girls in the Lincoln community. We do this through Advocacy, Youth Development and Family and Community Engagement.

YWCA Lincoln is pleased to provide this letter of support for Healthy Blue Nebraska. Healthy Blue has partnered and collaborated with YWCA Lincoln to assist us in serving our clients to the best of our abilities. Without the support of Healthy Blue, we would not have been able to serve over 95 families in the course of 3 months with hygiene products, which is a huge need within our community. YWCA Lincoln has also been able to, with the support of Healthy Blue, serve 30 families in the month of February with a large bag of fresh fruits and vegetables and a large bag of non-perishable food. Our clients depend on our continued support as a trusted community resource and without the partnership and support from Healthy Blue, it would be more challenging to fulfill the requests we have from our community in regards to our Family and Community Engagement Department.

Healthy Blue puts emphasis on helping our community and has been proactive in creating partnerships within our community. YWCA Lincoln is grateful for the partnership with Healthy Blue and is looking forward to continuing our partnership in the years ahead.

Sincerely,

Karen Bell-Dancy
Executive Director

for every woman

1701 S 17th Street, Suite #2E, Lincoln, NE | 402.434.3494 | www.ywcalincoln.org

CALLED TO CARE - Julie Godbout, Planning and Performance Director

I have worked in Medicaid at Healthy Blue for the past 5 years and it has been very rewarding serving members and working with other Healthy Blue staff. I am passionate about giving employees the tools they need to help members. It's a team effort.

CALLED TO CARE: This is not a 9 to 5 job for me; it's a mission to provide members with what they need to thrive. When offices were closed due to the pandemic, I spent more than an hour on the phone with a couple that used to frequent the Omaha Welcome Room. They needed help to navigate the value-added services and Healthy Rewards that they qualified for. A little while later, they sent me a Thank You card for the work that I did. Building relationships like this is one of the joys of my job.

VI.B. Technical Approach

Healthy Blue

No. 1

At Healthy Blue, we take compliance seriously and make it our responsibility to not only meet Contract requirements, but to also evolve and improve our services constantly to address the needs of members. ***We make sure any risk-bearing partners uphold the same high standards of advancing the health and well-being of members.*** When considering any potential risk-based contracting arrangement, we carefully select only the most qualified partners.

Proposed Risk Bearing Partnerships and Designated Functions of Each

Healthy Blue delegates functions under risk-bearing partnerships, as follows.

[redacted]

We use a comprehensive vetting process prior to entering a risk-bearing agreement to verify the capabilities of a potential partners and their ability to perform the functions we intend to delegate. Once a risk-bearing partnership has been established, we monitor their performance on an ongoing basis to confirm they are continuously meeting contractual and performance requirements. After delegation, we conduct regular performance reviews to ensure each partner continues to deliver high quality care to our members.

We integrate these delegated entities into our health plan operations to facilitate a seamless member experience. We collaborate on the development and use of criteria and clinical practice guidelines based on nationally recognized evidence-based practices, which go through the same review and approval processes as our internal guidelines. While we may delegate these activities, we maintain responsibility and accountability, including pre-delegation activities, ongoing monitoring, evaluation, and corrective actions where needed. We build trusted, collaborative, and long-standing relationships with our delegated partners to coordinate seamless service delivery. We will continue to meet all Contract requirements and remain accountable for our delegate entities' performance.

Oversight of Risk Bearing Delegated Entities

True to our commitment to full transparency and accountability, we maintain a Delegate Oversight Program to monitor delegated functions continuously in a collaborative manner. We monitor and evaluate delegate performance through daily collaboration, regular monitoring, and formal auditing processes. We will continue to oversee, monitor, supervise, and enforce compliance as well as promote frequent, open, and effective communication that emphasizes the delivery of quality services to members. Our performance monitoring processes confirm that each delegated entity meets operational, financial, legal, compliance, regulatory, accreditation, licensing and certifications, accreditation, and ethical requirements. We use a multi-layered approach to managing and overseeing our delegated entities, including:

- Delegate agreements that clearly outline roles, responsibilities, and expectations
- Delegate training for staff who interact directly with members
- Delegate reporting requirements and performance standards

Staff and Committees Support Multi-Layered Oversight of Our Delegated Entities

We consider delegate oversight a collaborative process that starts at the top of our leadership with our CEO, Dr. Robert Rhodes, and other executive leadership from Legal, Compliance, Quality Management, and other areas. Dr. Rhodes has been our Chief Medical Officer for more than two years and was recently appointed as CEO. With 25 years as a board-certified Nebraska family physician and former president of both Lancaster County Medical Society and the Nebraska Medical Association, Dr. Rhodes has a strong history working with providers and partners in the state. Reporting directly to Dr. Rhodes, Christine Cole is our Contract Compliance Officer and leads our Subcontractor Oversight Program, which includes delegated entities. Christine brings a decade of compliance experience, giving her valuable knowledge in overseeing delegated entities and their performance. She is available to MLTC should the need arise.

In addition, [redacted] This structure maximizes effectiveness in monitoring performance, enhancing accountability, and avoiding compliance issues.

For examples, several committees, in addition to our Medicaid Compliance Committee, provide governance and oversight of our delegates' operational performance. Through these committees, we audit operational performance data to drive discussion with health plan leaders to make sure all delegated entities are providing high standards of service and meeting all Contract requirements:

- **Delegation Oversight Committee:** Provides routine evaluation of the performance of delegates against contractual requirements and local, State, and federal regulatory requirements, and accreditation standards.
- **Operational Excellence Committee:** We launched an Operational Excellence Committee with responsibility for governance and oversight across multiple departments supporting Healthy Blue. The Committee includes representation from Claims, Quality, Network Compliance, Provider Data Management, Grievance and Appeals, Subcontractor Oversight, Encounters, and Reporting. The Committee's mission is to provide Healthy Blue's leadership with additional insight and to actively participate in all aspects of operations, including key performance indicators, remediation of risks, issues and challenges meeting operational performance metrics and contractual requirements. This is inclusive of subcontractor performance.

- **Joint Operations Committee (JOC) Meetings:** Evaluates delegate performance across all Medicaid affiliates to identify areas for improvement and introduce best practices pertinent to our local Delegate Oversight Program.
- **Quality Assessment and Performance Improvement Committee (QAPIC):** Assesses effectiveness of delegates' Quality Management and Utilization Management programs, which includes reviewing data to identify trends among delegates' denials and utilization patterns.

Table 1-1 highlights our continuous and frequent oversight activities for our risk-bearing partnerships.

Table 1-1. Healthy Blue Continuously Oversees and Monitors Risk-Bearing Partnerships for Performance and Contract Adherence.

Frequency of Oversight Activity	Description of Oversight and Monitoring
Daily	Our Delegate Oversight program staff are available as needed to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns.
Monthly	Our Contract Compliance Officer and staff meet monthly to review delegate's performance against standards, including trends and report submissions, and our QAPIC meets monthly to review quality and utilization management effectiveness.
Quarterly	We review performance with delegates during JOC meetings. These quarterly meetings also provide an opportunity to review health plan-specific initiatives, CAPs, and quality improvement goals.
Annually	Annual audits by the DOC confirm delegate meets operational, financial, legal, compliance, regulatory, accreditation, and ethical requirements.

Processes That Support Oversight of Delegated Entities

Our capacity to oversee and monitor delegates is enhanced through our dynamic systems and processes. Our structured approach begins with a thorough evaluation and pre-delegation audit prior to delegation. Once approved, we supplement annual delegation audits with regular operational performance oversight and monitor to confirm our delegates fulfill all contractual and performance obligations. When performance is subpar, we take corrective action to remedy the deficiency and educate our delegates to mitigate the risk of future performance issues.

- **Pre-Delegation Audits:** Delegates are thoroughly vetted to determine capability and capacity to deliver services that will support our members effectively and efficiently. Our audit tools are specific to functional area and based on contractual, federal, State, regulatory and accreditation standards. Our pre-delegation assessments review the delegate's understanding of applicable tasks, operational capabilities, performance record, fraud, waste and abuse violations, staffing ratios, HIPAA compliance, and references from the industry to verify they meet all operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements to perform the functions being considered for delegation.
- **Annual Audits:** Rigorous annual evaluations assure our delegates have the administrative capacity to continue performing delegated functions. The following is a general overview of the audit process: conducting formal desktop and on-site reviews; reviewing performance management reports; conducting audits of Delegate performance against requirements; identifying and communicating deficiencies or areas for improvement; and enforcing correction of any identified performance deficiencies or termination if deficiencies cannot be corrected. When issues of partial compliance and/or non-compliance are identified, the delegate must correct these deficiencies within a mutually agreed upon timeframe. Audit results are presented to appropriate Nebraska Medicaid committees for review, approval, and to determine next steps.
- **Performance Management:** We conduct ongoing operational performance monitoring through delegate performance reports that enable us to monitor for trends, identify deficiencies, and measure clearly identified key performance indicators against Nebraska Medicaid targets. Performance reports are unique to each delegate with Key Performance Indicators (KPIs) that are developed to account for the services being performed. Performance reports are reviewed monthly, with year-over-year data used to perform trends analysis to identify performance issues. We thoroughly analyze this data to identify potential anomalies, which may trigger a focused review.
- **Financial Solvency Reviews:** Our auditors, who are part of our Delegate Oversight team, conduct quarterly and annual financial reviews to assess the financial solvency of each external delegate. To conduct the review, we obtain a statement of revenues and expenses, a balance sheet, cash flows and changes in equity/fund balance, and IBNR estimates.
- **Corrective Action:** If at any time a delegate's performance does not meet contractual requirements or our expectations, we take corrective action. Our Contract Compliance Officer reviews all CAPs and tracks the status of each through resolution. After issuing a CAP, we monitor the progress of each action item within the CAP and promptly escalate any concerns and risks. If it becomes apparent that CAP implementation is not addressing areas of concern as expected, we determine the risk of the delegate's ongoing non-compliance and take appropriate action. The inability of a delegate to comply with Contract provisions leads to progressive corrective action, up to and including termination, depending on the severity of the issue.

No. 2

Maximizing the Number of Members with Relationships with Their PCPs

Healthy Blue understands that assuring all members are connected to and engaged with a PCP results in better health outcomes for the member. We equip members with information needed to choose their PCP, maintain simple processes and provide staff support to make that decision, and take every opportunity to emphasize to members the importance of a PCP, explaining that this is the provider that the member will see for most of their health care needs and will provide day-to-day health care. We promote to members the benefits of a member's PCP knowing the member's medical history, as well as the advantages of the member's medical needs being managed from one place; these efforts support our mission of helping people live the healthiest lives possible.

Assuring PCP Selection Within 30 Calendar Days

Healthy Blue prioritizes connecting members with PCPs and is compliant with SOW V.B.5. To facilitate establishing member relationships with primary care providers, each new Healthy Blue member will receive information through mail, phone and online channels that inform them of their assigned PCP and encourages them to make an appointment with their PCP. Members are also informed how to select a new PCP if they wish to change their assignment and offered help in doing so.

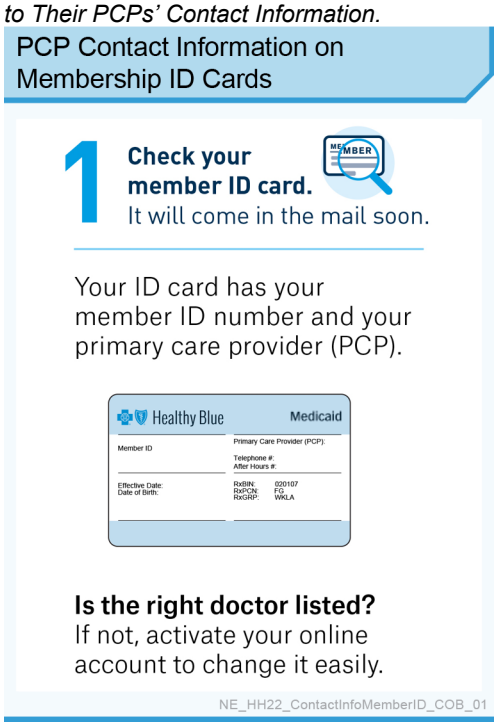
If a non-newborn, non-duals, member has not made a PCP selection upon enrollment, we auto-assign them to a PCP. All non-newborn members are assigned a PCP within 11 days, well within the one month requirement. Members have the flexibility to change their PCP upon request at any time. Our PCP auto-assignment logic, implemented in collaboration with MLTC considers the member's previous established relationships, demographics, and language preferences along with each providers quality metrics when assigning a PCP. If possible, we will assign a returning member to the most recent PCP to whom they were previously assigned. For new members we look to see if they have a family member assigned to a PCP that would be appropriate and, if so, assign the new member to this PCP.

Healthy Blue will continue to use our intelligent SMART Assignment algorithm to assign members to high-quality PCPs. The algorithm creates a personalized match for members that incorporates their provider quality and efficiency and geographic data using a priority provider hierarchy that includes PCMH preference, as the basis for PCP assignment. Eliminating distance and language barriers while assigning members to the highest quality PCP increases the likelihood of a meaningful member-provider relationship. Strong member-PCP relationships improve outcomes and reduce cost through less waste and better coordination for Heritage Health members.

Within eight calendar days of receiving the enrollment file, Healthy Blue will send a welcome packet to new members that includes key tools and resources for members. We also send out the member's ID Card which lists their assigned or selected PCP. As shown in Figure V.B.2-1, the welcome packet encourages members to connect with the PCP on their card or contact Healthy Blue to update their PCP selection. Members will be provided with a link to the Healthy Blue member website and information about accessing the online provider directory which lists all in-network PCPs and includes:

- Whether they are accepting new members
- Provider Gender
- Locations and Contact Information
- Hours of operation for each location
- Languages spoken at each location

Figure V.B.2-1. Members Have Easy Access to Their PCPs' Contact Information.



The welcome packet information also directs new members on how to access the member handbook on the member website, which includes information on the importance of connecting with a PCP and guidance on how to schedule an appointment. At any time, members may also opt to change their PCP online using our "Find Care" tool that includes providers' cultural and linguistic capabilities, including in-office translation capability.

Within 10 calendar days of the welcome packet being sent, all new Healthy Blue members receive a welcome call to confirm the assigned or selected PCP and explain their coverage and rights under the Heritage Health program, any need for translation services, or assessing any barriers to access to care. Healthy Blue also reaches out to pregnant members 60 days prior to delivery to encourage selection of a PCP for the newborn. In addition to the Welcome Packets and outreach calls made by Member Services Representatives (MSR), when a member joins and is auto-assigned a PCP, they also receive an automated call to alert the member, as well as inform them that they can change PCPs when they like. ***In 2021, 2,579 members were called through this automated communication process.***

Members can call the Member Services Call Center at any time to have a MSR help them schedule an appointment or change their PCP. If needed, MSRs will connect via three-way calling with the member and the PCP's office to assist with making an appointment. In person support for appointment scheduling is available in our Welcome Rooms. All providers have Heritage Health Member PCP Change Request Forms available. Members can ask their providers to fax this form into Healthy Blue and our Welcome Room staff will process those PCP changes. [redacted]

Examples of Successful Strategies and Lessons Learned

While we leverage our auto-assignment logic to connect the member with the most appropriate PCP, Healthy Blue also encourages members to choose their PCP for themselves and supports and incentivizes members to maintain a relationship with their PCP. [redacted]

[redacted]

Supporting Members to Connect with PCPs

One strategy that Healthy Blue uses to help higher need members maintain their relationship with their PCP is through the additional support of care management. Care Managers are the relationship builders and help introduce many members to the concept of how we can help with their whole person health. That begins by knowing who their PCP is, knowing them by name and knowing how to contact their PCP. Care Managers educate members on how a PCP is another support to help them better manage both their medical and social needs, prioritizing members with the highest need, those with comorbid (medical and behavioral) conditions and dual-eligible members. Care Managers are clinically qualified staff who are in regular contact with members will have developed a comprehensive profile on each of their members, including all their provider relationships, their most recent appointments, and any non-emergent use of the Emergency Department. Care Managers help coordinate follow-ups, such as annual check-ups with the member's PCP.

All members receive a health risk screener to determine any health or social risks, if any. If it is determined that there are health and/or social needs, a case manager reaches out to perform a more thorough health risk assessment and engages with the member to ensure they have a care plan. Part of developing the care plan is proper education on the benefits of a PCP and connecting the member with a primary care provider. Community Health Workers (CHWs) are another resource we use to engage the non-engaged member, if a CHW identifies a member that does not have a PCP, they can support that person to get connected to a PCP.

Gaps in care reports are also leveraged to connect members to PCPs. The Healthy Blue Quality Management (QM) team will review gaps in care reports and call members offering scheduling assistance and transportation assistance, if that is a barrier to care. The QM team also texts members. A member can respond with a simple "PCP" to get their PCP's contact information. Gaps in care reports are also sent to providers to support their efforts of engaging with members. In addition, Healthy Blue uses utilization data to deploy our emergency department (ED) diversion text campaign. After a non-emergent ED visit, a member receives text messages educating them on the various levels of care and how a PCP could help them avoid future ED visits.

Supporting PCPs to Connect with Members

Upon joining our network, every provider will be assigned to a dedicated Provider Experience Representative who will outreach to the provider to establish an initial meeting, welcome them into the network, provide orientation, and work with the provider to establish ongoing regular interactions. These consultants will also:

- Make providers aware of their member assignments via member panel reports when we assign them new members.
- Provide gap in care reporting to alert providers of what members are missing services.
- Promote incentives in value-based purchasing (VBP) agreements for completing preventive care visits.

Additionally, providers in VBP have access to our Provider Care Management System, which has a wealth of information that can be leveraged to identify which members may need focused outreach.

Leveraging Provider Performance to Improve Member-PCP Relationships

[redacted]

Lessons Learned Through Claims to Encourage PCP Relationships

Healthy Blue uses claims to identify, validate, and correct member information in multiple ways. [redacted]

No. 3

Healthy Blue recognizes that complete, accurate, and timely member enrollment data are critical to our operational functions and vital to supporting members. [redacted] On average, we process daily 834 Medicaid enrollment files within six hours of receipt. In cases where members have not selected a PCP by day 11 following receipt of the enrollment record, PCPs are assigned. This significantly exceeds the State requirement that they be assigned a PCP within 30 days of the enrollment record being received. We allow the member to change their PCP at any time and our enrollment data reflects the member's choice. We also process monthly files and reconcile discrepancies as part of our quality process to verify that all membership is aligned accurately between our systems.

Using MLTC Enrollment Files to Manage Membership

When we are notified of new members through receipt of an 834 eligibility file, we assign each a unique number to track and manage the individual throughout all systems, including those of our subcontractor partners. We maintain analytical reporting to monitor membership enrollment at an aggregate level as well as at a detailed eligibility category or member demographics level. This enables us to tailor our operational strategy based upon current enrollment, geographic dispersion, and member profiles.

Our enrollment load process supports MLTC's enrollment processes and requirements. As necessary, we add or update member demographic and eligibility information using data from daily and monthly 834 files and monthly 820 capitation files, according to specified timelines. We maintain complete eligibility history for all members using uniquely dated spans to manage variation in benefit category and product. This allows us to maintain a complete timeline of participation in the programs.

[redacted]

Process for Resolving Discrepancies

We have an established and effective process for resolving discrepancies between MLTC files and internal records when they arise. We retrieve all 834 eligibility files using a secure FTP site and subject all files to HIPAA compliance edits before processing. If the file passes those checks, we perform additional edits against criteria, such as field length, field type, and required data elements. We evaluate each record on the daily 834 eligibility file and execute appropriate business rule checks, whether it is an addition, termination, change, or void, and update our Core Service Platform (CSP) accordingly. Our process includes logic to compare member demographic data on the incoming 834 eligibility file against our data to make sure that we record the most current member information. The enrollment file load process establishes "begin" and "end" dates for members under their current program eligibility category. Members' eligibility information may change periodically, and we capture those changes promptly and accurately while maintaining historical data. This level of detail enables us to provide appropriate services and accurately process all claims, even when the member's eligibility changes after the claim date of service. Our daily process generates reports that list member-level activity and identifies any errors. Our Enrollment team then reviews the reports and investigates records that could not auto-adjudicate within 24 hours. In 2021, all issues were resolved, and records processed within 48 hours. The investigation may involve correcting data in our CSP, checking MLTC files for member information, and sending a secure email message to MLTC for clarification. If clarification with MLTC is needed, the secure email message is sent within 24 hours of receiving the report of discrepancy.

Addressing Differences in Member Addresses

We recognize that 834 data is the source of truth for member' addresses, and we capture address information from MLTC's enrollment file in members' eligibility records within our systems. As members move and addresses change, they may not report these changes in a timely manner to the State, creating a gap between the current address and what is being sent on the 834 files. Because up-to-date contact information is critical to our ability to reach and engage members, we take proactive steps to identify inaccurate or outdated addresses and track down current address information, including:

- Verifying member contact information, including email address, during welcome calls to members within 30 days of enrollment.
- If an ID card is returned for an incorrect address, we use an advanced reconciliation process to monitor for claims with an updated address over the next 90 days, with the goal of identifying an updated address where we can send the card.
- Verifying, and updating if appropriate, home address every time a member calls the Member Services Call Center.
- Using a vendor file from NEHII with phone number data, a comparison to our database is made and phone numbers we do not have on file are added to the system.
- Notifying MLTC of change whenever we receive a new address for a member.

Member Reconciliation

We perform several reconciliations each month, using daily and monthly 834 files and monthly 820 files. Our process reconciles daily 834C files to monthly 834F files. We compare the State's 834 and 820 files to data in our system to identify members on the 834 or 820 file who are not in our system and members in our system who are not included in 834 or 820 files. We use enrollment data to make important linkages and close gaps in care. Our reconciliation process generates discrepancy reports, which our Enrollment and Billing teams carefully review. They add members on the 834 or 820 files who are not already in our system and initiate new member processes. For those in our system but not on 834 or 820 files, we review all enrollment data previously received to confirm we did not receive a termination record. We then submit discrepancies and reconciliation requests to MLTC.

No. 4

Healthy Blue focuses on engaging members to make sure we are addressing their needs and preferences and preventing issues before they arise. Care management, single-case agreements, and strategies to enhance the member experience are all part of our regular practice to engage and support members and address the challenges that can lead to disenrollment. For members who request to disenroll from our plan, we will first take steps to identify and quickly address the reason whenever possible. If the member does not experience resolution, we direct the member to the enrollment broker. When a member is requesting disenrollment for cause, they are guided to make a verbal or written filing of the issue through the Healthy Blue's Grievance System. These processes are conveyed transparently to members in the member handbook, and we maintain policy and procedure documents on each process.

Disenrollment

Since the inception of our contract, the volume of members seeking to disenroll has been too low to identify any disenrollment trends. [redacted]

Members may disenroll within initial 90 days of enrollment and during open enrollment for any reason. If a member does choose to disenroll, we will work to assure the continuity of a member's care upon disenrollment. This includes assisting in the selection of a PCP, cooperating with the new PCP in transitioning the member's care, and making medical records available to the new PCP. We also follow Transition and Coordination of Care Plan guidelines whenever a member is transferred.

We treat every request for disenrollment as an opportunity for improvement. We will contact members to understand the reason and, if they were to choose to disenroll, administer a disenrollment survey. We will track these survey results to identify trends at least monthly, and report through our Quality Assessment and Performance Improvement Committee and our Service Quality Committee quarterly. We also analyze survey results against any grievances and appeals or quality concerns to further pinpoint trends and address opportunities to improve members' experience. For any trends or results we identify, Performance and Quality Improvement Coordinator Brittany Kuhns will oversee improvement activities in conjunction with department leadership to make changes in programs and operations, as needed.

In Table V.B.4-1, we identify examples of Healthy Blue interventions to avert disenrollment.

Examples of Healthy Blue Interventions to Avert Disenrollment

Table V.B.4-1. Interventions to Avert Disenrollment.

Disenrollment Intervention	Example of an Effective Diversion Scenario
Care Management. Our Care Management team engages with members to address their needs and concerns. A member of the Care Management team will outreach to a member requesting disenrollment to identify whether the concern can be resolved. If the Care Management team cannot resolve the issue or connect the member to other resources to resolve it, they will work with the member to support a smooth transition to the MCO of their choice.	Our CM reached out to a member requesting disenrollment to find out what their concerns were and seek resolution. The CM learned that the member was upset about denial of a medication for their child. The denied medication readily dissolves under the tongue. This was their preferred medication as they were concerned about their child's ability to properly ingest a tablet or liquid. The CM explained that the specific medication requested was not covered by Medicaid and her concern would not be resolved by changing MCOs. Instead, the CM discussed alternatives with the member and their physician, including an option for an alternative form of the requested medication. The physician agreed and issued an amended prescription that satisfied the member and avoided disenrollment. The CM was able to also discuss other condition management resources, as well as related value-added services, during this process to strengthen our relationship and help reduce some of the ongoing caregiver strain the member was experiencing.
Network Capacity Development and Single-case Agreements. Members engage more effectively with providers they choose, and often choose their MCO based on whether their preferred provider is in the network. We continuously evaluate our network capacity and ensure that our members have access to a variety of skilled providers. However, if a member has a preferred provider not in our network, we will reach out to invite them to join our provider network. When that is not feasible, we may also use a single-case agreement so that the member can continue to receive services with their preferred provider.	A member requested to be disenrolled from plan because the behavioral health provider with whom they wanted to seek treatment was not covered by the plan. Our Care Management team worked with the member to review other options within our provider network while our provider team engaged with the provider to invite them to join our network. In this case, the provider was not interested in joining the network, but was amenable to accepting the member as a new patient via a single-case agreement. The member was able to receive coverage for to continue services with their preferred provider and chose to retain coverage with the plan.
Enhancing the Member Experience. A member's satisfaction with their care, from the MCO Care Management team or their providers, may impact disenrollment requests. To address this and enhance the experience of our members, we offer an array of training options for both our Healthy Blue team members as well as our contractors and providers, such as: trauma-informed care; motivational interviewing; vicarious trauma (how a person can be impacted by another person's trauma experience), cultural sensitivity, health equity, etc. We also collect member and provider satisfaction surveys and routinely engage with	In the previous pharmacy example, the member was a tired mother who wanted a medication in a particular form, not necessarily because it was medically indicated, but because the mother strongly believed the particular form was the best method for her child. The CM was able to learn this through motivational interviewing strategies and effective listening. By truly learning the cause of the discontent, the CM was able to address not just the medication concern but also talk through other issues of importance to the family.

Disenrollment Intervention	Example of an Effective Diversion Scenario
stakeholders to explore opportunities for improvement. As noted previously, our Care Management team reaches out to members requesting disenrollment. Communication is extremely important at this point, so we equip our Care Management team to navigate these conversations with unbiased, respectful, and sensitive strategies. Using thoughtful motivational interviewing strategies, our Care Management team talks with the member to learn whether there are underlying financial or relational stressors that may be impacting their overall satisfaction.	

No. 5

Process for Identifying Unborn Individuals Beginning Coverage at Time of Birth

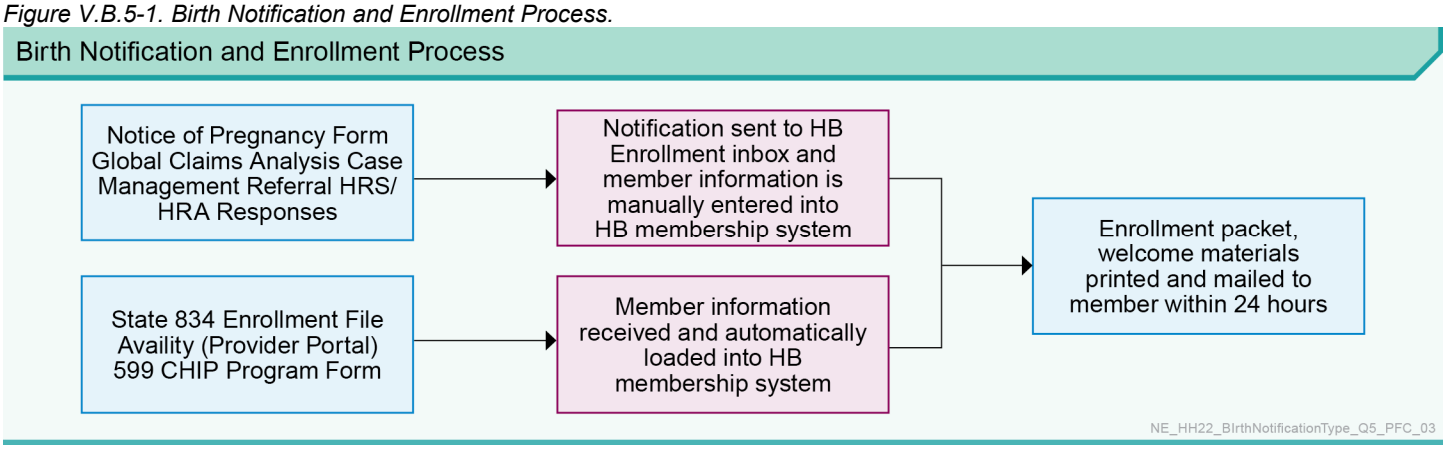
Healthy Blue employs a variety of methods to identify unborn individuals that will require Medicaid coverage upon birth, including, but not limited to:

- **State 834 File.** We review all enrollment files to identify members who are pregnant and alert our clinical team about new pregnant members for risk screening and assessment.
- **Notice of Pregnancy Form.** We provide training to all our providers on the completion and submission of this form, as well as its importance.
- **Availity Maternity Application.** Providers can also notify Healthy Blue by submitting a maternity attestation on Availity, the provider portal.
- **Global Claims Analysis.** We analyze and monitor claims submissions for pregnancy-related claims. Complementing enrollment file data, we regularly mine our claims and other data. There are claims based triggers for both pregnancy tests and ultrasounds, which help to identify a pregnancy and yield the opportunity to educate on selection of a pediatrician.
- **Direct Case Management Referral.** We educate all employees about the importance of identifying pregnant members and engaging them in care coordination services.
- **Health Risk Screening (HRS)/Health Risk Assessment (HRA) Response.** A question regarding pregnancy is routine on assessments and during welcome calls.
- **599 CHIP Outreach Program.** While we often receive information about 599 CHIP members through the 834 file, we also engage mothers through our NICU outreach efforts, enrolling infant members post-birth to assure coverage and care in their first months of life.

Enrollment and Care

Depending on the method of notification, the unborn or infant member is enrolled in one of two ways, as illustrated in Figure V.B.5-1.

Figure V.B.5-1. Birth Notification and Enrollment Process.



A shared enrollment inbox receives information from Healthy Blue staff or providers. The enrollment information is then manually entered into our system. Notifications received through the State 834 file, Availity, or a 599 CHIP form are automatically entered into the enrollment system. Once the information is loaded into the enrollment system, a member ID and welcome package is printed overnight and shipped to the infant member, care of their mother. Infants are covered as independent members immediately upon birth, regardless of the eligibility status of their mother. We understand that mothers of 599 CHIP infants lose all covered services when the baby is born. Our Care Management team works with the mother to locate community resources to provide services, such as diapers, car seats, and maternal post-partum care. In one such case, a 599 CHIP member was outreached after being identified as a newly enrolled member. After completing an HRS with one of our Outreach Care Specialists, the member's mother agreed to case management services and was referred to one of our OB Care Managers. The OB Care Manager continued to engage this member throughout her pregnancy as the member was hopeful to have a vaginal birth after cesarean (VBAC) after a previous cesarean section. The OB Care Manager provided prenatal education and supported member to advocate for herself to the OB about her wishes for a VBAC. During the last month of pregnancy, OB Care Manager helped mom obtain a breast pump and encouraged her to seek postpartum care through local low- or no-cost clinics. The mother had an uncomplicated vaginal delivery of a baby girl, and both are doing well. Additionally, we will educate mom to report the birth to AccessNe as soon as the baby is born for continuity of care.

Selecting a PCP

HEALTH EQUITY

Understanding the importance of health care in an infant's first months, our natal care team waits the requisite 14 days to auto-assign the newborn to a PCP if one is not selected by the mother. To facilitate the selection of a PCP prior to birth, we provide education to the infant's mother via My Advocate™ on how to choose a PCP. As part of prenatal care, the mother's PCP or obstetrician counsels the pregnant member about plans for their child, including designating the family practitioner or pediatrician to perform the newborn exam and choosing a PCP for the infant to provide subsequent pediatric care to the child. Upon our receipt of 599 CHIP notification, we send a letter to the member, care of their mother, about the importance of choosing a PCP, and include our customer service phone number to call for assistance.

No. 6

Collaborating with Other MCOs to Ensure Coordination of Care — Ensuring a Seamless Transition

Because changes in health care and benefits can cause unneeded stress for members, Healthy Blue works diligently to assure smooth transitions, including when a member is transitioning from one MCO to another.

We manage members' transitions through a variety of methods, including:

- Educating members on the transition of care process and supports
- Maintaining continuity of care by collaborating with other MCOs, providers, and discharge planners
- Making sure transitions produce successful outcomes
- Dedicating Care Managers to assist members with transitions and help ensure continuity of care

Our transitional care management includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of member and family caregiver needs, coordinating the member's discharge plan with the family and hospital provider team, collaborating with the hospital or institution's care coordinator/case manager to implement the plan in the member's home, and facilitating communication and the transition to community providers and services.

We leverage our established processes and partnerships in place with the State, other MCO contractors, as well as hospitals and community providers, to support continuity of services. Our dedicated Case Manager Transition Coordinator (CMTC) manages the transition of members between Healthy Blue and other MCOs. Upon notification from MLTC that a member is leaving or entering Healthy Blue's enrollment rolls, our CMTC engages the corresponding MCO to begin the transition.

Heathy Blue and the corresponding MCO exchange a clinical summary, in accordance with federal and State laws regarding HIPAA, that includes, but is not limited to:

- The member's care plan(s) for any relevant programs in which they are enrolled
- Social supports and potential SDOH needs
- Prior authorized services
- Inpatient hospital utilization history
- Medication summary
- Comprehensive provider listing to include the PCP and BH providers

As part of the exchange of information, the following conditions apply:

- Healthy Blue provides member Medicaid ID numbers to the previous MCO's secure portal for those they will need to transition care
- The supplying MCO provides the data/report to Healthy Blue's secure portal within three business days
- The aforementioned information is exchanged through formats ranging from SFTP, secure email, and direct phone calls between Care Management staff

We assign a Care Manager to each member transitioning to Healthy Blue. Our Care Manager receives all the member information from the supplying MCO. The Care Manager engages with their counterpart at the supplying MCO to obtain the member's existing care plan. The member then undergoes a new member Health Risk Assessment. They update the care plan as appropriate and work with the member to ensure a continuation of care and seamless transition between health plans. The member's PCP is an integral part of their continuation of care, and one of our priority tasks is to engage the PCP and bring them into our network. While Healthy Blue works to bring the member's PCP and other providers into the network, we take financial responsibility for the member's continuation of care for at least 60 days after the effective date of enrollment.

Transitions during Inpatient and Residential Stays

At times, some members experience transitions between MCOs while they are hospitalized or while receiving care in alternate care settings. Due to the elevated stress for the member and the uniqueness of the situation, we work to assure a seamless transition for the member. We provide the member's new MCO with a clinical summary which includes:

- The member's care plan including social supports
- Prior authorized services
- Inpatient hospital utilization history
- Medication summary
- Comprehensive provider listing to include the PCP and BH providers

If the member is transitioning in or out of our plan, we communicate with the facility to ensure clarity in understanding of ***our*** and ***their*** financial responsibility to the member's current and discharge needs. We work closely with the new MCO to verify all gaps in care and services are identified and resolved regardless of which plan is responsible for payment.

No. 7

Ensuring Compliance with Part 438 of Chapter 42 of the CFR (Federal Regulations around Medicaid Managed Care), Title 471, 477, and 482 NAC

As an incumbent in Nebraska, Healthy Blue has five years of experience in maintaining compliance with federal, state, and the Nebraska Heritage Health requirements, including all relevant provisions of Part 438 of Chapter 42 (Managed Care) of the CFR and Titles 471 (Nebraska Medicaid Program Services), 477 (Medicaid Eligibility), and 482 (Nebraska Medicaid Managed Care) of the Nebraska Administrative Code. Our compliance program components and resources represent a comprehensive, proactive approach to program monitoring and enforcement. We have complied with all contract requirements and applicable state and federal laws and regulations since the program's inception, providing the fullest protection of members' rights and fully supporting the DHHS' program goals. Our compliance program's system of processes and controls is founded on the Office of Inspector General's fundamental elements of an effective compliance program, including:

- Designating a Compliance team that includes a Contract Compliance Officer, Compliance Manager, and Compliance Committee
- Implementing written policies, procedures, and standards of conduct
- Conducting effective training and education
- Maintaining accountability through reporting and investigation
- Conducting internal monitoring and auditing
- Enforcing standards through well-publicized disciplinary guidelines, responding promptly to detected offenses, and undertaking corrective action

Our Compliance Team

Our Compliance team features three fundamental levels of oversight, including support from our national leadership:

- ***Program Integrity Officer, Jennifer Bohnhoff***, has deep, focused expertise on these programs, including any federal and state legislation or initiatives that may affect the program. With a thorough understanding of contract requirements, she answers questions about state requirements, provides guidance, verifies that we meet state deadlines, and promotes accurate and timely reporting. Jennifer maintains a comprehensive repository of all our contractual requirements and commitments.
- ***Contract Compliance Officer, Christine Cole***, is dedicated to the Nebraska market and reports to CEO Robert Rhodes, MD. She is the primary contact for MLTC on all MCO contract compliance issues. Christine is responsible for coordinating the preparation and execution of contract requirements, tracking the submission of all contract deliverables, answering inquiries from MLTC, and performing random and periodic audits and ad hoc requests.
- ***Healthy Blue's Compliance Committee***, led by our Program Integrity Officer, Jennifer Bohnhoff, includes leadership from our parent company; plan leadership, including our CEO, Robert Rhodes; and subject matter experts from the Special Investigations Unit, Compliance, Program Integrity, Quality Management, Utilization Management, Care Coordination, Operations, Regulatory Reporting, Vendor Management, Marketing, and Provider Services departments. The committee meets quarterly and reviews contract requirements and all performance reporting and metrics for accuracy and efficiency, promptly addressing any gaps. It also conducts oversight and review of all departments, programs, and subcontractors. Through the Compliance Committee, we can use the extensive resources and best practices of our parent company's national Medicaid Compliance department.

National resources complement our Nebraska compliance program with supplemental oversight, guidance, and best practices, gained over the past 30 years in more than 25 other Medicaid markets. Our layered approach to compliance includes the Nebraska Compliance Committee and program, the Medicaid Compliance Committee and program, and our parent company's overall Health Compliance Committee and program.

Written Policies, Procedures, and Standards of Conduct

Healthy Blue manages all Medicaid policies and procedures using a uniform process, with support and oversight from a specialized and dedicated Policy and Procedure team. The Policy and Procedure team manages active policies and procedures across our organization's Medicaid health plans to promote compliance with federal and state regulations governing Medicaid Managed Care, accuracy, and version control. Policy and procedure development, review, and document maintenance follow a standard process that begins with an initiating action to:

- Create a new policy and procedure or update an existing policy and procedure based on a regulatory or business need
- Perform an annual review of an existing policy and procedure

Regardless of the initiating action, all policies and procedures are developed, reviewed, and updated by subject matter experts in each functional area, such as claims processing, case management, and regulatory reporting. Clinical policies and procedures receive an additional level of review by one of our medical or quality committees. Our Nebraska Compliance team reviews all policies and procedures that apply to our Nebraska programs.

Compliance Training and Education

All employees receive quarterly training that includes an overview of MLTC, its policies, our contract, and state and federal requirements governing our plan. Additionally, all employees undergo "Do the Right Thing" ethics and compliance training, including modules on fraud, waste, and abuse (FWA), within 30 days of hire and annually. Department-specific training (for example, claims, utilization review, and quality assurance) is provided periodically. The training explains reporting procedures and asks employees to remain vigilant about FWA indicators.

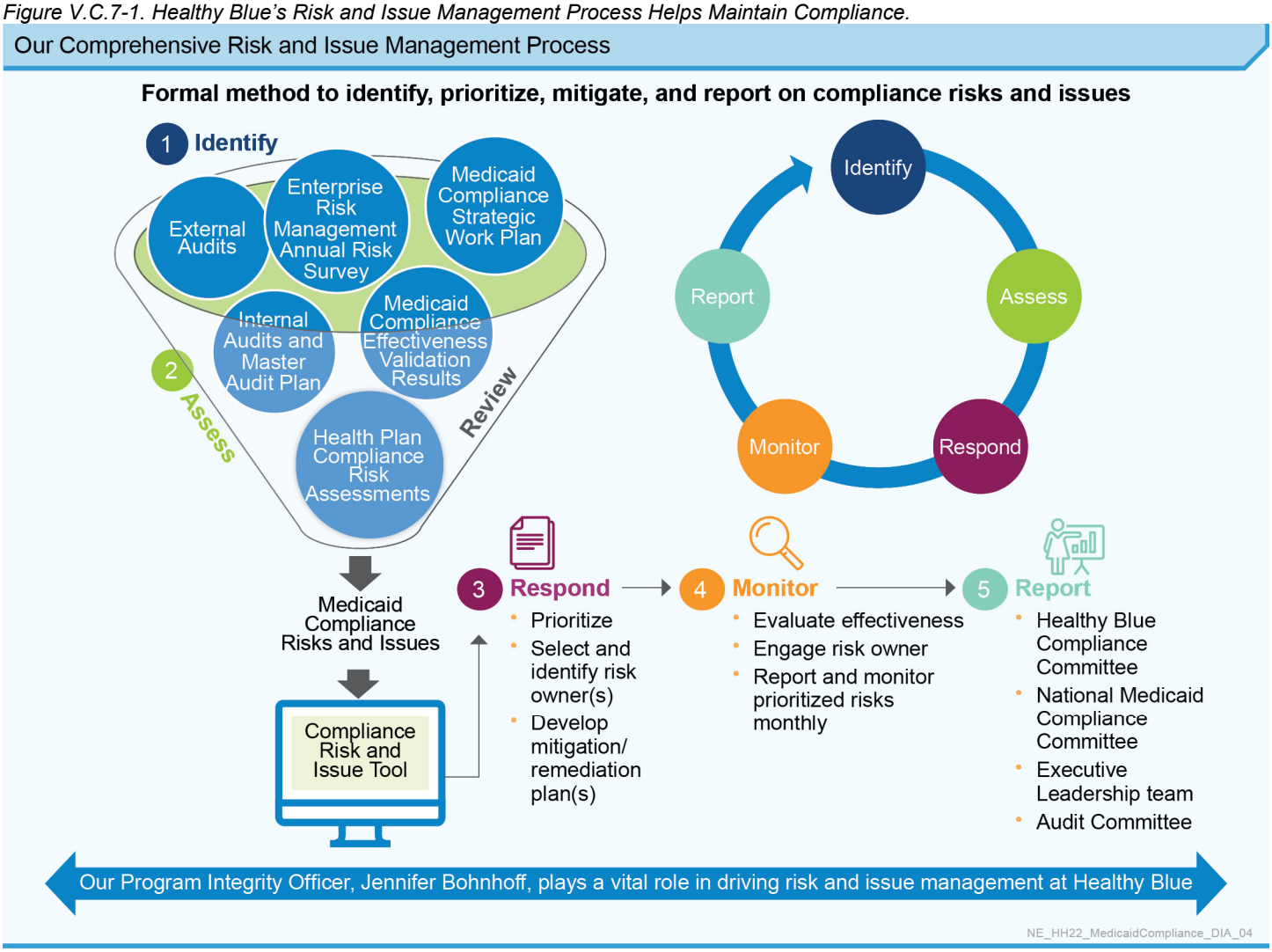
We deliver a modular FWA course through our web-based learning platform as part of our overall compliance training that meets federal, state, and local requirements. Course topics and knowledge checks include information security; reporting security concerns; employee misconduct; Medicare compliance; duplicate billing; False Claims Act and whistleblower protections; medical coding, including miscoding, upcoding, and unbundling; overutilization; member safety; and services not rendered. We update the curriculum periodically to reflect changes in FWA rules, regulations, policies, and laws. The Compliance team monitors attendance to make sure that all employees complete courses in accordance with contractual requirements.

Proactive Internal Compliance Monitoring and Auditing

Through our dedicated Compliance team, we work closely and openly with DHHS to promote compliance within our Medicaid program and to resolve issues before they become compliance concerns. When risks or issues are identified, they are entered into our centralized tracking tool by Compliance, reviewed closely with the aid of responsible business partners, and monitored until resolved. Our Compliance department regularly reviews contract requirements with our department directors to check compliance with existing requirements and any new changes. Additionally, our Compliance team partners with our legal counsel to provide collateral reviews and clarification from a contractual perspective as an additional safeguard in maintaining compliance standards. Our Compliance team constantly reviews and updates all internal corrective action plans, and we use the knowledge and experience of our affiliates in other states, including any emerging trends.

As summarized in Figure V.C.7-1, we follow a formal method of identifying, prioritizing, mitigating, and reporting on compliance risks and issues that supports early identification of emerging trends and provides peer-to-peer support to define optimal mitigation strategies. The attention of senior-level leadership throughout the process and through various committees facilitates resource commitments and full transparency.

Figure V.C.7-1. Healthy Blue's Risk and Issue Management Process Helps Maintain Compliance.



We support our process with ***sophisticated tools, such as Compliance 360, a risk-tracking application that helps us stay up-to-date on new laws and regulations***. Through Compliance 360, we track contract changes, new state or federal laws or regulations, and updated state guidance. We use our Compliance 360 tool to alert relevant departments about the changes. Each department has at least one assigned assessor. Assessors review alerts, analyze the associated documentation, and document any tasks necessary to implement a required change in process or procedure. Compliance 360 monitors all assessments and documented tasks to support timely completion, all within a single system.

We also monitor contract compliance through performance measure reporting. During our tenure serving Nebraska, we have developed significant experience in tracking, monitoring, and reporting performance measures both internally, through an executive dashboard, and externally to DHHS. Through this reporting and with the aid of a quarterly reporting dashboard prepared by our specialized Regulatory Reporting Center of Expertise, we closely review all performance reports.

Clear, Accountable, and Transparent Reporting

As a partner to DHHS from the beginning of the Nebraska Heritage Health program, our Compliance team has fostered a culture of transparency and accountability through clear reporting to stakeholders and meeting important performance and quality outcomes. Our long-term and ongoing experience with DHHS' development and enhancement of its reporting needs provides us with a unique depth of understanding of the reporting processes and the information those processes are intended to produce. We know what DHHS needs from us to effectively monitor, analyze, and improve Nebraska programs, and we remain committed to providing all that is needed and required. As evidence of our commitment to the accuracy of regulatory reporting, our CEO, Robert Rhodes personally reviews every regulatory report before its submission to DHHS. [redacted]

Our team's central, ongoing objectives include continued partnership with DHHS and the other MCOs to drive even greater consistency in reporting across MCOs as well as significant and sustained improvements to Healthy Blue's reporting systems and processes. We have recently instituted an enhanced tracking process that will produce reports further in advance of their due dates. This enhanced process allows more time for in-depth review and further validation of reports before their submission, limiting the risk of delays.

Our health information system has helped us streamline, coordinate, and more fully automate our reporting processes. Our system gives us the flexibility to nimbly respond to changing state needs and requirements. It contains built-in controls to promote the accuracy of data feeds and has eliminated many manual processes in reporting, thereby reducing the administrative effort of collecting, analyzing, and producing actionable information and reducing the risk of manual error. Our health information system and process enhancements provide the following key benefits to DHHS:

- Central accountability with our CEO, Robert Rhodes
- Enhanced integrated data infrastructure, which allows for faster and more accurate reporting, allowing for internal review and timely submission
- Ability to do a thorough review with built-in controls driven by variance analysis
- Provides information to our expert business owners and management, who can use data streams and access resources to research and resolve potential issues
- Dashboards developed for senior leadership to monitor performance
- Data warehouse designed for warehouse data extraction

Our enhanced reporting process supports the collection and reporting of relevant data to DHHS through both regulatory and ad hoc reports. Healthy Blue collects all data required to generate DHHS reports during program operations. System and process enhancements have made it easier for Healthy Blue to actively partner and collaborate with DHHS to produce responsive, timely, and accurate data. Additionally, our enhanced quality controls increase confidence in our reporting results.

Enforcing Compliance Standards

In the event we have a performance measure at risk for noncompliance or out of compliance with contract requirements, we immediately engage the responsible business owners and develop a mitigation strategy and improvement plan to address the risk and prevent it from reoccurring.

When risks or issues are identified, the Compliance team logs them, reviews them closely with the aid of responsible business partners, and monitors them until they have been resolved. Compliance regularly reviews contract requirements with our department directors to assess compliance with existing requirements and any new changes. Our Compliance team constantly reviews and updates all internal corrective action plans (CAPs), incorporating the knowledge and experience of our affiliates and any emerging trends.

If a functional area has not met the Compliance team's established goal, the team may create an internal CAP. The CAP documents background details; impacted functions; root cause analyses; mitigation strategies; and detailed actions, including steps to correct issues with assigned business owners, due dates, and regular updates. Our Program Integrity Officer, Jennifer Bohnhoff, and relevant health plan leaders oversee this CAP. Compliance and Operations will monitor the CAP through resolution.

No. 8

Meeting Federal Definition of an MCO

As a licensed MCO in the State of Nebraska since May 1, 2016, Healthy Blue meets the federal definition of an MCO as outlined in 42 CFR Part 438.2. Healthy Blue is a private entity that meets advance directives requirements as determined by the Secretary and provides services to its Medicaid enrollees that are accessible in terms of timeliness, amount, duration, and scope. Healthy Blue meets the solvency standards of 42 CFR Part 438.116.

Please refer to Attachment V.C.8-1 for a copy of our Certificate of Authority.

No. 9

Collaborating with Other Entities and Programs

As a partner to MLTC for five years, Healthy Blue has processes and procedures in place as well as designated points of contact for collaboration with other entities and programs that serve our members. Our model emphasizes whole patient-centered health care that champions individual choice and engagement, and our relationships with State entities and programs that serve members is integral to this philosophy. Healthy Blue's staff work collaboratively with multiple local and State-based stakeholders, including members and their families/foster families, advocacy organizations, providers, community-based organizations, and other State entities to provide access to the full continuum of integrated services.

Single Point of Contact for Collaboration

Each entity we collaborate with has a single point of contact within Healthy Blue assigned to coordinate efforts with that agency or program.

NE_HH22_SinglePoint_COB_01

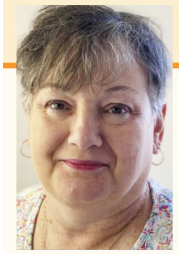
We value the relationships we have built working with State agencies and programs to serve Nebraska members. We adapt our process for coordinating care management with State staff based on each agency's or program's needs and preferences. At a minimum, our process includes:

- **Single Point of Contact.** Within Healthy Blue, we provide a dedicated point of contact for each agency or program we work with to facilitate smooth collaboration and planning efforts.
- **Agency-specific Coordination Procedures.** Our dedicated point of contact for each entity or program works with State staff to establish procedures for coordinating care management. As part of this process, we develop workflows, coordinate on referrals, and detail communications preferences and frequency.
- **Initial Outreach.** When we identify that a member is receiving case coordination from the State, and with permission from the member, our Care Manager (CM) initiates contact with State coordinators or appropriate staff based on the established coordination procedures. We discuss next steps, coordinate efforts for the member's multi-disciplinary team meetings, share existing care plans (with member permission for sensitive diagnoses), and collaborate on care planning.
- **Ongoing Collaboration.** We coordinate efforts with State staff from initial identification of State care management through care planning; provision of integrated, whole person services; and follow-up. With member permission, we share assessments and care plans with our State partners. If a State care plan exists, we incorporate it into our own care plan. We invite personnel from the agency or program to participate in multi-disciplinary team meetings, where all providers and participants in a member's care share updates and information regarding the member's goals and progress. We include State staff and all members of the multi-disciplinary team in post-discharge planning to further assure continuity of care and coordination of services.

The following highlights our experience working with other entities and programs, as required in Section V.C.5.

Division of Behavioral Health-funded programs

Throughout our five years of experience serving Nebraska, our behavioral health (BH) clinical leadership has worked with the Division's staff to help link members to the most appropriate BH programs to address their needs. Our BH Clinical Program Development Manager and Tribal Member Advocate, Teresa Zahren, is the point of contact for these programs. She recognizes how critical these collaborative relationships are in supporting a healthier Nebraska and continues to foster partnerships and coordination wherever possible. Some of the Division of Behavioral Health (DBH)-funded programs we collaborate with include the Nebraska System of Care for Youth, Behavioral Health Network of Care, and the Nebraska Behavioral Health Regions. We recently collaborated with Lorie Thomas, Licensed Clinical Social Worker (LCSW), Manager of Transition Services for Region 6 Behavioral Healthcare to facilitate a care conference to connect members with complex care needs to medically necessary services and social and community supports.



CALLED TO CARE
Teresa Zahren, LCSW

I have worked at Healthy Blue since 2016 and enjoy my role as Tribal Member Advocate and Behavioral Health Subject Matter Expert. In my current role, I draw on my experience of working with children and families as a therapist and working in the child welfare system. I also consult with Care Managers and work with Indian health care providers to offer better health care support for Native Americans, who are especially dear to me and part of my family.

CALLED TO CARE: I grew up in a small town and have always had a heart for rural areas and the strengths they offer to families. From an early age, I knew I wanted to pursue behavioral health as a career path and started my career working in the child welfare system with foster children. I have always had a heart for children who are abused, neglected, and removed from their home. I am so grateful to be doing this work that helps create better lives for them.

NE_HH22_ TeresaZahren_MW_03

Our staff collaborate with DBH in a much deeper way than through only regular meetings. Our staff get involved at the community level with programs and organizations to better understand members' behavioral, medical, and social determinants of health (SDOH) needs. For example, our BH Clinical Director, Dr. Martin Wetzel, served on the Long-acting Injectable Committee with Douglas County Jail staff, Douglas County Health Department, and Douglas County Attorney's Offices, now the Familiar Faces Project at the Douglas County Jail. Dr. Wetzel also participated in the Region 6 Committee, evaluating needs for psychiatric emergency department services in Douglas County, and now serves on the community advisory committee for the University of Nebraska Medical Center Psychiatric Emergency Service. Dr. Wetzel also serves on the DBH Committee to evaluate Lincoln Regional Center members' needs and how to better serve those needs through efficient coordination with MCOs.

Healthy Blue is currently engaged in several DBH-funded projects designed to improve and enhance Medicaid services, including:

[redacted]

[redacted]

Division of Children and Family Services-funded programs

Healthy Blue is committed to collaboration with Division of Children and Family Services (DCFS)-funded programs to support the safety, permanency, and well-being of children in the care and custody of the State. Teresa Zahren, our point of contact for this agency and its programs, meets monthly with DCFS leadership, Karen Moran and Alison Wilson. The purpose of these meetings is to maintain ongoing communication and collaboration, especially regarding foster care and wards of the State population. [redacted]

[redacted]

Our BH and physical health (PH) Case Managers who are assigned to foster care members immediately conduct outreach when we receive new members and continue to follow up throughout the initial week to make sure that those members needs are being addressed. Our Behavioral Health Manager, Shannon Calabrese, LIMHP, LADC works with DCFS to get care for State wards and quickly meet their ad hoc and emergent needs. We immediately assign these members to a dedicated child/adolescent specialist Case Manager who can get these members the services and care they need. We also participate in staffing meetings with Dr. Janine Fromm, the Executive Medical Officer at the Department of Health and Human Services (DHHS), to understand how we can better assist DCFS with service and care coordination for the members' behavioral and medical needs and any SDOH drivers.

Division of Developmental Disabilities Programs

Healthy Blue's Collaboration with Local Universities

In partnership with Healthy Blue, University of Nebraska's Munroe-Meyer Institute (MMI) provides Healthy Blue members with Intellectual and Developmental Disabilities (I/DD) with:

- Autism spectrum disorders (ASD) treatment
- Behavioral health
- Developmental medicine
- Early intervention
- Feeding and swallowing services
- Occupational/physical/recreational/ rehabilitation services

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We support the Division of Developmental Disabilities (DDD) programs in Nebraska that serve members in Home and Community-Based Services (HCBS) waiver programs, and offer services and supports that compliment, not duplicate, existing programs and resources. Teresa Zahren serves as the point of contact for DDD programs. To better serve members on waiver programs, and in the spirit of collaboration with DDD programs, we recently presented training on Nebraska Waiver services to all of our care management staff. As a result, our care management staff better understand DDD programs and can provide more productive assistance to members in these programs. Our CMs often collaborate with Developmental Disabilities (DD) Service Coordinators to avoid overlap or duplication of services. For example, one of our CMs worked with the Assistive Technology Partnership (ATP) for a member who needed home modifications due to a disability. At the same time, this CM collaborated with member's DD Service Coordinator when the cost of the member's home modifications needed more funding. Together, they reached out to League of Human Dignity and Easter Seals of Nebraska to supplement ATP's assistance. [redacted]

It is critical that we also collaborate with other entities that facilitate developmental disability programs, as many of our members with intellectual and DD are on waiver waiting lists. Our Care Management team works with organizations such as the Department of Vocational Rehabilitation, Commission for the Blind and Visually Impaired, Commission for Deaf and Hard of Hearing, Munroe Meyer Institute, League of Human Dignity, and the Nebraska ATP to help our members access health and social services to meet their holistic needs. Nebraska is not alone in its struggle to address waiting lists for HCBS waivers. We are dedicated to supporting members across the continuum of care so they can maximize their health an independence. [redacted]

The Nebraska Department of Education Early Development Network

Healthy Blue supports collaborative efforts with Nebraska's Early Development Network (EDN), co-led by the Department of Education and MLTC, as an early intervention for families with children up to three years of age who have developmental delays and Special

Health Care Needs. Case Manager Amy Lauby is our point of contact to the EDN and together with our CMs frequently refers members to the EDN when appropriate. Once verbal consent is obtained from the member's guardian when needed, a Healthy Blue CM provides the referral to the appropriate EDN agency. We then follow up with the member's guardian and their family to confirm that they have made contact and will continue to facilitate connection between the EDN and member if necessary.

Community Agencies (Including Area Agencies on Aging and the League of Human Dignity)

Our point of contact, Amy Senn, RN, is committed to working with community agencies such as Area Agencies on Aging and the League of Human Dignity. For any member who qualifies for services from community agencies, we assign them to a Care Coordinator who maintains direct contact with these agencies and the member to make sure that services are accessible and appropriate for that member. Our relationships with these agencies foster continued success in seamless care for members.

The Office of the Courts and Probation

We understand how important collaboration can be in getting the right supports for members involved in the courts and juvenile justice system. To that end, Teresa Zahren, the point of contact, meets monthly with the Office of the Courts and Probation to discuss plans for adults and for children. During these meetings, we facilitate an open and collaborative discussion with Office of the Courts and Probation leadership on services, programs, claims, and provider concerns. We include other department contacts in these discussions as needed, including team members from our Provider Promise program, Government Relations, and CMs who can speak to individual member cases. Additionally, Healthy Blue supports the RISE Academy Nebraska Reentry program. [redacted]

Resolving Coordination of Care Issues

With designated points of contact for each entity we coordinate with, we can proactively identify and address issues that arise in the day-to-day coordination of care activities. We base our processes for coordinating with providers and State staff on feedback and lessons learned through our years of experience serving Nebraska. We designed our processes to assure continuity of care, regardless of whether services are provided through managed care, fee-for-service, other State contractors, or community and social support providers. To coordinate across the continuum of care, as part of the care management process, our Case Managers decrease the potential for duplication of services and fragmentation of care by:

- Identifying services a member is currently receiving, the providers who deliver the services, and any State staff who may be providing care management support for members
- Contacting providers and State staff to coordinate assessments and become active participants in the member's multi-disciplinary team
- Incorporating State or provider-created care and treatment plans into our information management systems
- Providing multiple resources for State staff and providers to communicate with our Care Management team, including a secure, dedicated email inbox, a one-touch referral function in the provider portal that feeds to the Care Management team, and a dedicated phone line to the Care Management team that is available to providers and members

Healthy Blue conducts integrated clinical and BH rounds weekly or more frequently as needed to address a variety of clinical issues and populations, including children in specialized care, members with chronic PH conditions, neonatal intensive care, obstetrics, applied behavioral analysis, outpatient care, members in psychiatric residential treatment facilities, and other conditions and populations. Our physician-led multi-disciplinary team rounds include clinical CMs; physicians; BH providers; representatives from State agencies, such as DBH, DCFS, or DDD; and other entities relevant to specific cases.

Because our focus is on sharing actionable information and insights with partners, we have a robust and flexible infrastructure and suite of capabilities to transfer, analyze, and visualize data compliant with all applicable privacy laws and regulations and safeguarded through business associate agreements. We have all clinical and social data and file transfer capabilities, such as Health Level 7 transactions and SFTP, and actively participate in secure data exchange to better coordinate care. CMs have access to members' utilization history and can view upcoming procedures. Data-sharing agreements allow our Care Management team to confirm providers have obtained test results from hospitalizations. Our prior authorization process checks previous utilization to avoid duplication of services.

System Transformation and MLTC-identified Planning Initiatives

Healthy Blue collaborates with the aforementioned entities and program network providers on MLTC-identified planning initiatives and system transformation. The following examples are just a couple of our recent collaborations:

- [redacted]
- [redacted]

No. 10

Healthy Blue Accreditations

Healthy Blue is currently accredited by the National Committee for Quality Assurance (NCQA) and is in the submission process for Multicultural Health Care (MHC) Distinction. We expect to have MHC distinction in July 2022. Additionally, we will pursue Health Equity Distinction when NCQA opens the application period.

Our Florida affiliate health plan is one of nine organizations participating in the Health Equity Plus Pilot with NCQA. We intend to implement best practices in Nebraska from our affiliate's experience in this pilot program.

Our Affiliates' NCQA Distinctions

Six of Healthy Blue's affiliates hold **NCQA Long-Term Services and Supports (LTSS) Distinction**, and 17 affiliates hold **NCQA Multicultural Health Care Distinction**.

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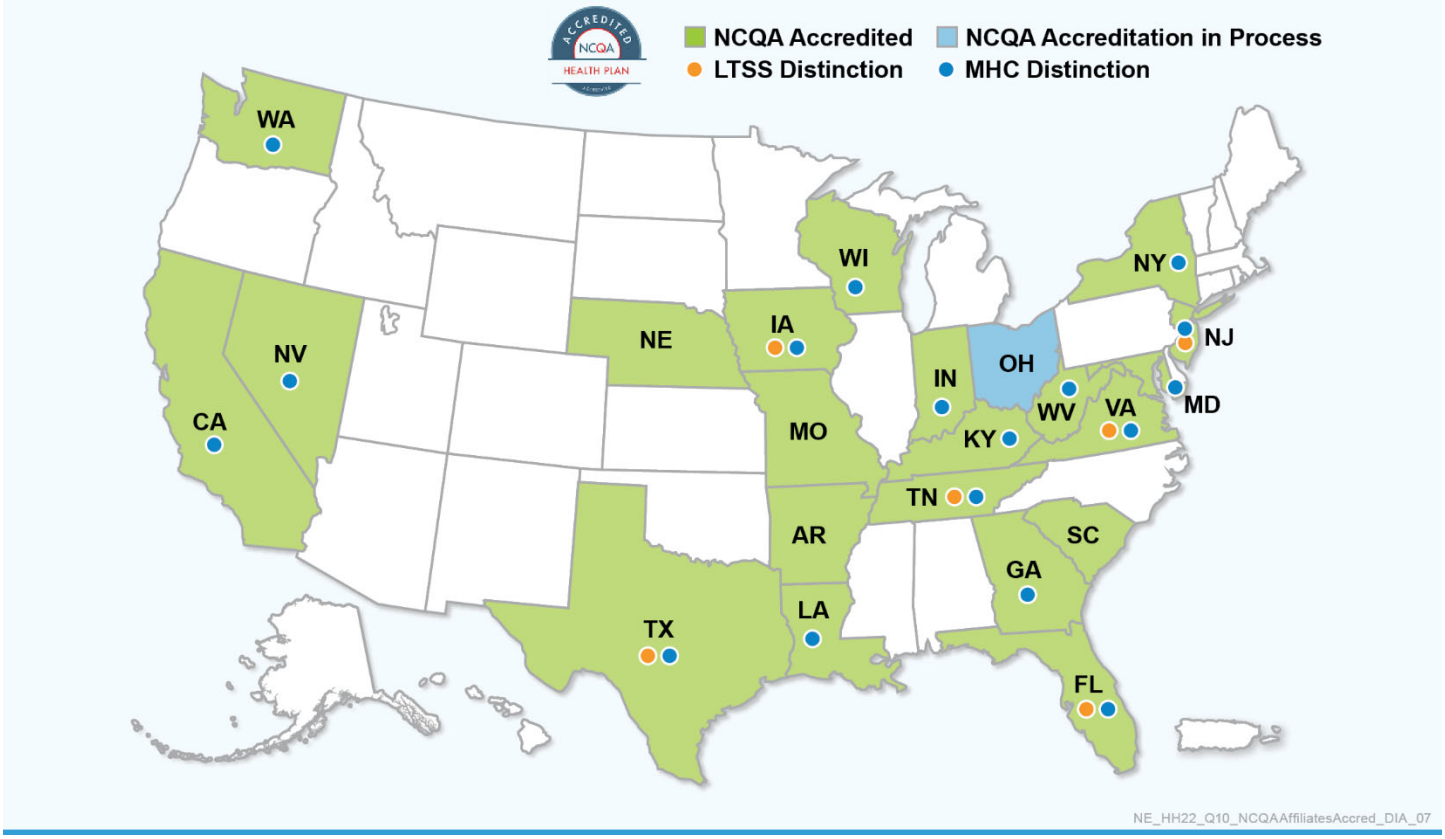
Our Affiliates' Accreditations

Healthy Blue has affiliates accredited in states including Arkansas, California, Florida, Georgia, Iowa, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Nevada, New York, Ohio, South Carolina*, Tennessee, Texas, Virginia, Washington, Wisconsin, and West Virginia. All of our affiliates currently hold NCQA accreditation status, with the exception of our affiliate in Ohio, which is in process of obtaining accreditation. Healthy Blue and our affiliates have not made any unsuccessful accreditation attempts. Figure V.B.10-1 shows our accredited affiliates by state, with distinctions.

Figure V.B.10-1. Healthy Blue's Accredited Affiliates.

Our Affiliates' NCQA Accreditations and Distinctions



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*Provides administrative support services to a local health plan contracted with the state to administer Medicaid benefits who holds the accreditation.

No. 11

Objections on Moral or Religious Grounds

Not applicable. Healthy Blue provides access to all Medicaid services for our members and does not restrict any provision of services, reimbursement for services, or provision of coverage for a counseling or referral service because of objections on moral or religious grounds.

No. 12

Organizational Overview

Since 2017, Healthy Blue has served Nebraska Heritage Health, administering the delivery of physical health, behavioral health, pharmacy, vision, and transportation services to members across the State. Our belief has always been that health care solutions are more effective when developed and delivered locally, and we benefit from our partnership with BCBSNE and its 80 years of Nebraska experience. Nevertheless, we built our structure solely for Nebraska's Heritage Health program. We keep our Nebraska staff at the helm of our operations and directly accountable to DHHS, members, providers, and stakeholders.

Healthy Blue maintains autonomy and decision-making for the Nebraska Medicaid business and is solely responsible for the management of this contract. Healthy Blue's Chief Executive Officer, Robert Rhodes, MD, leads our health plan operations and staff, enabling agility and local decision-making to deliver on our mission and organizational goals. As shown in Figure V.D.12-3 at the end of this section, our structure centers on local accountability and control.

The organizational structure provides the framework and accountability needed for successful execution and to meet all the contractual requirements of the SOW. The organizational structure is designed to:

- Focus on the member and whole person health
- Employ local leaders who come from and understand the communities where the members live
- Maintain excellence in our operations
- Promote provider partnership

Local Accountability and Presence, Backed by National Expertise

Our parent company, Elevance Health, Inc. (previously known as Anthem, Inc.) supports a proven Local Health Plan Staffing Model, currently operating successfully in 26 state-sponsored health program markets. This model consists of a comprehensively staffed Nebraska-based team responsible for, and accountable to, meeting and exceeding major job objectives for all key member- and provider facing functions, as well as vital operations that support the overall program, the community, and the State. Our Nebraska-based team will continue to work and communicate with DHHS on a daily, ongoing basis, to foster the development of a strong collaborative relationship between our staff and State staff. With senior Healthy Blue personnel living and working in Nebraska, we will work closely with DHHS and make sure that we implement and manage all program components effectively, that members have access to all medically necessary services in a timely manner, and — in collaboration with network and community-based providers—that our services meet the highest standards of quality. Our affiliates have helped state agencies in other markets build solutions to various health care and service challenges, and we will continue to work with DHHS to do so in Nebraska as well. Our team will also be responsible for continuously reviewing program performance and enhancing the program as needed.

We employ staff who fully understand the MLTC program and needs of Nebraskans across the State, especially the diverse highly complex populations we serve through the Nebraska Heritage Health program. We also fully appreciate the importance of continuity and tenure within our staffing to assure that the State, members, and providers have access to employees who have Nebraska-specific expertise and are consistently available to address their specific support needs. Our employees are highly qualified and experienced to perform the duties for which they have been hired and will have sufficient training to provide exemplary, culturally competent, and timely services. Healthy Blue uses a well-structured and methodical staffing and training process that we have successfully implemented with repeatable results.

The local, Nebraska-based team has full ownership of the program and helps assure that decisions regarding service delivery and administration are made at the local level. The team collaborates closely with providers, community programs, State and local agencies, and other stakeholders to help assure MLTC's program objectives are achieved. Additionally, we drive accountability through shared goals that are built into each employee's annual performance evaluation, which drives a highly collaborative and team approach in meeting the goals and objectives of the program. To supplement our current Nebraska-based team, we are adding numerous new, locally based positions, labeled "Nebraska Investment Positions" in Figure V.D.12-3 and our organizational chart in V.D.13.

Our Nebraska-based ***Health Equity Director***, Tiffany White-Welchen, is a Nebraska-licensed mental health practitioner and professional counselor with more than 15 years of experience as a behavioral health (BH) Clinician and executive leader working with underserved, under-represented, and vulnerable populations. Ms. White-Welchen works in close conjunction with the clinical leads to oversee day-to-day coordination and integrated delivery of services that address the total health needs of members, including social determinants of health (SDOH). Our structure includes local Quality and Provider Services, Community Impact, Claims Education, and Tribal Liaison staff who work together in cross-functional teams, making sure that all member and provider needs are met.

Our team includes subject matter experts trained to address the needs of providers serving our specialized populations. These employees are co-located with our behavioral, and clinical teams, which helps assure efficient coordination to resolve issues for the provider and ultimately, the member. Our structure maximizes teamwork and draws on each individual's strengths to achieve goals that align with DHHS objectives, with a clear vision to create a customer-focused, innovative, high-quality, and adaptable managed care system. Through clear lines of reporting and authority, we prioritize responsiveness, flexibility, and ultimate accountability of our key staff across all areas of operation.

A detailed organizational chart is in V.D.13 and list of FTEs is provided in V.D.14. We adhere to the contractual requirements delineated in the SOW including the preclusion from a staff member holding more than two key positions (with one key position for the CEO, Medical Director, and Dental Director) and we exceed the required ratio of positions based in the State to those that may be filled from a national support perspective. All employees, whether Nebraska-based Healthy Blue or national Medicaid support, are subject to rigorous standards for screening, including verifying credentials initially and then assuring maintenance of licensure or other credentials. All positions are posted and have position descriptions which detail the responsibilities and requisite qualifications of the position.

Under the direction of our Nebraska-based key staff, our parent company and its affiliates provide additional Healthy Blue-designated support services staff to supplement our local resources and meet DHHS program requirements and realize administrative efficiencies. Healthy Blue obtains support services from our parent company, a leading health company serving more than 118 million people that

provides administrative functional support; AIM Specialty Health, providing evidence-based guidelines in radiology, cardiology, oncology, specialty drugs, sleep medicine, musculoskeletal and pain management, and genetic testing; IngenioRx, a Pharmacy Benefits Manager; and Beacon Health Options, a BH Management managed care company. These support services resources are directly accountable to our CEO as demonstrated in Figure V.D.12-1.

[redacted]

Number of Employees

Healthy Blue is a constant and committed partner, continually working alongside the DHHS to assure the coordination and delivery of care and support for members and improve the overall effectiveness of the Nebraska Heritage Health program. Our staffing plan consists of [redacted] in Nebraska, and more than [redacted] (shared services).

We continually review our staffing numbers and quality and service standards to determine whether we need additional employees to support members and providers. We require each manager and department to routinely review their specific responsibilities and determine the capacity of the current department by monitoring any changes in volume, membership, program updates, and service delivery to adjust staffing levels to meet members' needs. Our Nebraska leadership works closely with their counterparts in our affiliate health plans to share innovations and best practices, review new processes and programs, and determine whether global or systemic changes may be required to maintain or enhance service delivery. Based on the information we identify, managers refine existing staffing plans, identify additional resources that can be rapidly mobilized, continue to provide required training, and work with other departments to identify operational efficiencies. For example, when we added our Health Equity Director, we consulted with affiliate plans that already had this position to learn about best practices for the new role.

Lines of Business

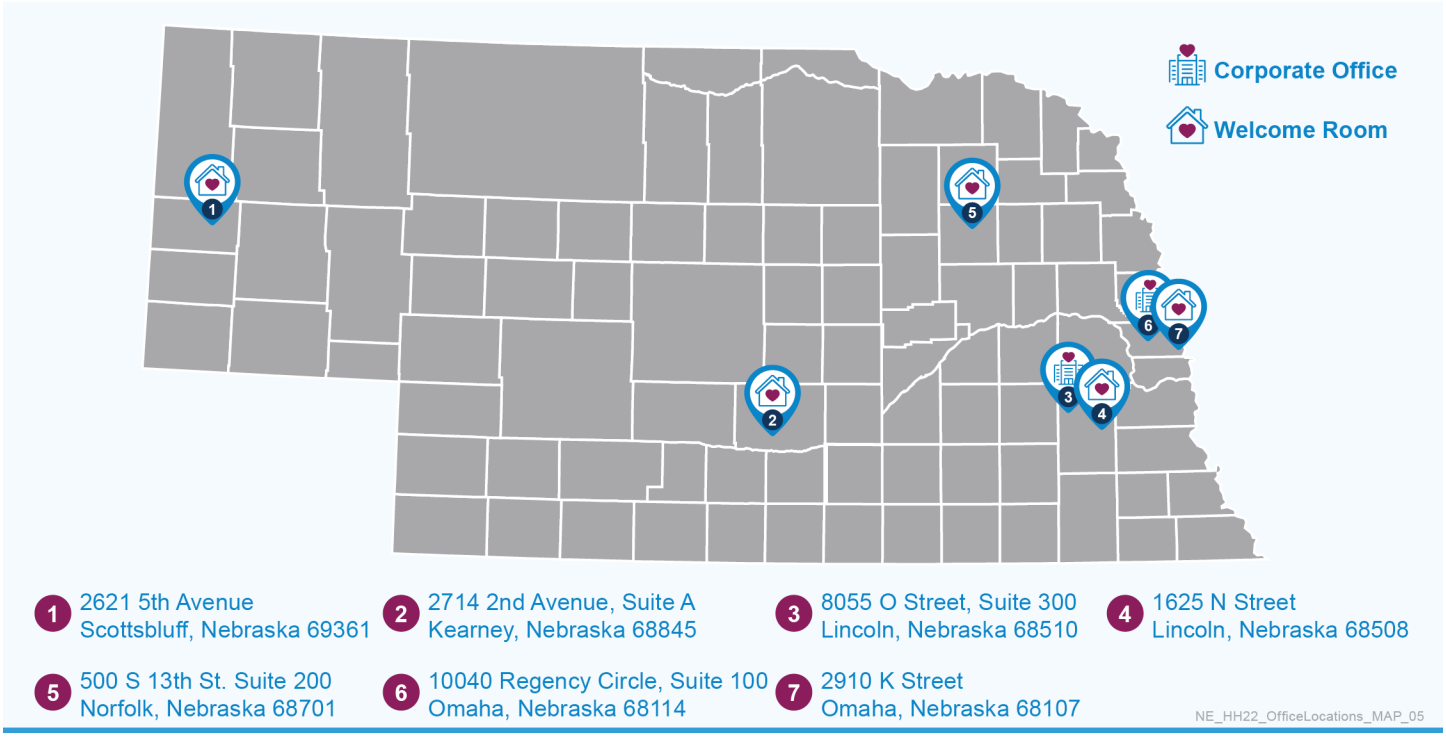
Our Healthy Blue team supports two lines of business, Medicaid and CHIP. We are aware of the DHHS requirement for all MCOs to have in place a statewide Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) by January 1, 2024. We have begun discussions and will be preparing to meet that requirement with the assistance and expertise of our affiliates that already operate SNPs in 22 markets, including seven HIDE SNPs.

Office Locations

We maintain office locations across the state to reach members in their communities. We recognize that the needs of members will vary and have geared our outreach in consideration of all ends of the state. Figure V.D.12-2 highlights our office locations, including our Welcome Rooms. This is one of our primary outreach strategies to support members via face-to-face interactions in achieving their wellness goals and to encourage self-management of care along with new, healthy behaviors. Welcome Rooms invite members and community partners to engage with Healthy Blue Representatives. These locations offer resources like classes, seminars, educational materials, member support, and are important for receiving quality of care feedback from our community. While almost 80% of our membership is distributed in urban areas, that leaves aver 20% in rural and frontier counties. Our geographic distribution of providers and office locations is designed to meet members closer to home.

Figure V.D.12-2. Healthy Blue's Offices Span Across the State.

Nebraska Healthy Blue Offices and Welcome Room Locations



National Support Services

Our National Support Services group provides specialized, centrally delivered services that complement local employees in the functional areas that we strategically determined create both better value and results for our state partners and members. The group is composed of national experts designated to Healthy Blue and Nebraska Heritage Health. In addition to bringing the State increased efficiency and economies of scale, the national team will continue to actively support Healthy Blue health plan employees, and they, too, are accountable to DHHS through shared goals that drive continued and effective cross-functional collaboration.

This team leverages innovations and lessons learned from our affiliate health plans and facilitates the sharing and use of best practices in state-sponsored program administration with the local team. They also created a peer-mentoring program that allows our health plan employees to access national support resources to collaboratively develop and implement best practices across the Iowa program in a seamless manner. Together, they continuously evaluate and enhance the program with up-to-date insights and experiences from their national exposure.

National Support Services functions include:

- Telephonic care management
- Claims and encounters processing staff
- Member and Provider Services Call Center
- Information systems
- Actuarial services
- Legal advisory and oversight
- Human resources

The combined strengths of this model enable a fully accountable local team to benefit from the years of cumulative institutional and customer knowledge and experience our national teams possess. All designated employees will be knowledgeable about and follow all Nebraska Heritage Health program requirements, and their functions will be fully accountable to the local leadership team.

[redacted]

No. 13

[redacted]

No. 14

[redacted]

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No. 15

Position Title: Chief Executive Officer (CEO)

Job Description:

Our full-time, Nebraska-based CEO is responsible for providing overall direction and prioritization for Healthy Blue, developing and carrying out leadership strategies, assuring that policies and contractual requirements are followed, providing operational oversight to assure that goals are met, and developing and implementing integration models that assure coordination with system partners. This job is required to be based in Nebraska.

The CEO oversees the strategic direction, administration, and management of our Heritage Health program services. This includes responsibility for the following:

- Serves as the thought leader at the helm of innovation and impactful changes that will maximize Heritage Health program efficiency and responsiveness
- Maintains full accountability to DHHS as Contract Officer to assure timely and effective delivery on all contract requirements
- Aligns strategy to achieve business goals and build a culture of accountability with people who are results-driven, innovative, and committed to excellence
- Secures and coordinates the top-level talent and resources necessary to meet all contract requirements
- Builds strategic partnerships with community organizations, State agencies, providers, and all stakeholders in the Nebraska system of care
- Maintains accountability to make decisions about coordinated care activities and represents Healthy Blue at meetings required by DHHS
- Remains accountable for profit and loss management responsibilities, including cost management, budgeting, forecasting of premium rates and renewals, and growth
- Oversees and participates in the development of growth and retention strategies, including marketing and communication initiatives based on the changing needs of our members
- Monitors and manages implementation of key Nebraska regulatory and legislative requirements and processes, including eligibility, benefits design, networks, administrative requirements, and new programs and services
- Establishes policies and processes to assure continuous compliance across the organizations

Qualifications:

Experience:

- Experience with Nebraska Medicaid and/or CMS quality program management and accreditation process, which should include a working knowledge of population health programs that are common to Medicaid managed care
- At least 10 years of direct experience within the health care field, preferably in an MCO in Nebraska or in a comparable capacity
- Experience in administering services that support members with complex conditions
- Experience in building relationships with stakeholders and in implementing new programs and services
- Strong knowledge of Medicaid, managed care philosophy, and extensive local knowledge of Nebraska communities, resources, providers, State agencies, and stakeholders

The CEO must have extensive local knowledge and understanding of the populations and communities we serve in Nebraska to help drive Healthy Blue operations in meeting the needs of our members, providers, and DHHS. This includes familiarity with the Nebraska legislature. This role requires exceptional management, communication, analytical, and problem-solving skills, including negotiation and conflict resolution. The CEO must have an approachable, collaborative style with an eye for talent and be a champion of inclusion and diversity. The CEO must also be able to keep leadership and the entire team's focus on members and making sure the programs and services we provide are responsive to their needs.

Education:

Bachelor's degree in relevant area of study; master's degree preferred

Position Title: Medical Director/Chief Medical Officer

Job Description:

Our full-time Nebraska-licensed and locally based Medical Director/Chief Medical Officer position oversees the delivery of covered services and clinical decision-making for Healthy Blue. Dedicated full-time to Heritage Health program administration, this role spearheads all clinical functions and serves as a leader for our care management, care coordination, population health, and utilization management (UM) areas. This job is required to be based in Nebraska.

Our Medical Director/Chief Medical Officer r is accountable for all clinical operations, programs, and services, with responsibilities that include the following:

- 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
- Administrating medical management activities
- 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
- Leading the UM, Quality Management (QM), Credentialing, and Provider Advisory Committees
- Manages the administration of physical and/or behavioral health (BH) medical services to assure members receive the most appropriate care and supports
- Approval of all clinical and QM policies
- Provides clinical consultation and serves as clinical/strategic advisor to enhance clinical operations
- Supports clinical staff to ensure timely and consistent responses to members and providers by providing guidance and consultation on referrals, denials, grievances, and appeals
- Reviews and addresses potential quality of care issues, which includes participating in the development, implementation, and oversight of corrective action plans
- Conducts peer-to-peer clinical reviews with attending physicians or other providers to discuss review determinations
- Serves on Quality workgroups as required by DHHS, including the Nebraska Coordinated Care Quality workgroup
- Plays an integral role in overseeing and developing clinical practice guidelines and clinical policies and procedures
- Liaises between Healthy Blue and providers
- Participates in integrated rounds in tandem with our Population Health, BH, and Perinatal Health Directors to support and provide consultation to clinical staff on individual treatment plans
- Serves as a resource and consultant to other areas of the company, including QM, to help assure the highest HEDIS® and National Committee for Quality Assurance (NCQA) ratings
- Participates and/or chairs committees, including Quality Management Committee, Clinical Services Committee, Medical Policy and Technology Assessment Committee, and Health Equity Advisory Council
- Leads, develops, directs, and implements clinical and non-clinical activities that impact health care quality cost and outcomes
- Identifies and develops opportunities for innovation to increase effectiveness and quality
- Oversees clinical staff who meet weekly to evaluate demographic information, medical information, and social determinants that can influence a member's pattern of care, and design interventions to avoid admissions and readmissions
- Participate in advisory committees, associations, and/or organizations that provide strategic clinical guidance to regulators and legislators

Qualifications:

Experience:

The Medical Director/Chief Medical Officer must be a currently practicing physician, with an unrestricted license in the State to practice medicine. The Medical Director/Chief Medical Officer must have a minimum of three years of training in a medical specialty and five years of experience providing clinical services. The Medical Director/Chief Medical Officer must devote a minimum of 40 hours per week to Heritage Health's operations to assure timely medical decisions, including after-hours consultation as needed. The Medical Director/Chief Medical Officer must be board-certified in their specialty and be actively involved in all major clinical, UM, and QM decisions. The Medical Director/Chief Medical Officer role requires excellent communication and facilitation skills, along with the ability to analyze and resolve complex issues. This position must also have in-depth knowledge of managed care, relevant State and federal regulations, and proven ability to build and maintain positive working relationships with providers, community-based organizations, and stakeholders.

Education:

Current Nebraska license to practice medicine with no restrictions or limitations. Must also be board-certified in a specialty recognized by the American Board of Medical Specialists.

Position Title: Dental Director

Job Description:
The Dental Director is primarily responsible for the UM and utilization review programs and assuring the timely oral health decision-making and prospective requests for dental services (referrals and pre-authorizations). They formulate reviews to peer-to-peer requests and conduct peer-to-peer calls. The Dental Director is responsible for assuring that the dental benefit operated by Healthy Blue is compliant with standards of dental care and consistent with Nebraska Heritage Health requirements. The Dental Director establishes and coordinates the implementation of Healthy Blue oral health strategy to assure comprehensive, whole-person health. The Dental Director is involved in clinical review activities, tele-dentistry, and Special Investigation Unit (SIU) activities. They are an active participant on the National Peer Review, UM, Credentialing, and QM/Quality Improvement (QI) Committees. The Dental Director complies with all applicable federal and State statutes and regulations, is available Monday through Friday, between 8:00 a.m. and 5:00 p.m. CT for utilization review decisions, and is authorized and empowered to represent the Dental Benefits Manager (DBM) regarding clinical issues, utilization review, and quality of care inquiries.

Qualifications:

Experience:
- Two+ years' experience of training, processing, and policy experience preferred
- Five+ years' experience as a practicing dentist
- Experience working with State health programs
- Knowledge of current dental terminology, practices, materials, and generally accepted standards
- Knowledge of clinical dentistry procedure codes and generally accepted clinical and adjudication guidelines on the medical necessity of proposed dental procedures
- Ability to examine and read dental radiographs and chart records
- In-depth knowledge of managed care delivery systems, reimbursement mechanisms, QI initiatives, and the reduction of unnecessary costs

Education:
- DDS/DMD degree required
- Currently licensed in Nebraska as a Doctor of Dentistry (“dentist”) with no restrictions or other licensure limitations

Position Title: Behavioral Health Clinical Director

Job Description:

The Behavioral Health Clinical Director is responsible for providing clinical case management consultations and clinical guidance for contracted PCPs treating BH-related concerns not requiring referral to BH specialists, developing comprehensive care management programs for youth and adults with BH concerns, typically treated by PCPs, such as ADHD and depression, and developing targeted education and training for PCPs that commonly encounter BH issues.

This role spearheads the development and implementation of our policies, procedures, and programs related to BH services. As a licensed physician specializing in BH, this role builds relationships, serves as a liaison between Healthy Blue and providers and drives our comprehensive suite of culturally competent solutions supporting those with mental health or substance use issues. The Behavioral Health Clinical Director oversees and is responsible for all BH activities within Healthy Blue, and takes an active role in our medical management team and in clinical and policy decisions. Responsibilities include the following:

- Develops and manages programs and initiatives related to BH, including case management services, our 24-hour BH services line, and our BH network of providers
- Works closely with UM staff to identify and address potential under- or over-utilization of BH services
- Provides consultation and guidance for staff on referrals, denials, grievances, and appeals
- Reviews and addresses potential quality of care issues, including participating in the development, implementation, and oversight of corrective action plans
- Serves on Quality workgroups as required by DHHS
- Acts as liaison to BH providers for peer reviews and consultation on evidenced-based practices and clinical guidelines
- Collaborates with staff across our affiliates and national organization to leverage evidence-based BH programs and customize them to address the needs of our Nebraska members
- Participates on committees, including the Quality Management Committee, Clinical Services Committee, and Health Equity Advisory Council
- Develops and drives initiatives that increase provider awareness on interventions and supports available for BH
- Serves as the primary liaison with BH community resources, including community mental health centers and specialty providers
- Participates in developing and reviewing clinical practice guidelines and clinical policies and procedures
- Participates in integrated rounds to support and provide consultation to clinical staff on individual treatment plans

Qualifications:

Experience:

The Behavioral Health Clinical Director must be a currently practicing psychiatrist or psychologist with an unrestricted license in the State. This position requires a minimum of five years of combined clinical experience in mental health and substance use disorder services and be knowledgeable about primary care/BH integration.

The Behavioral Health Clinical Director must have strong oral, written, and interpersonal communication skills, including the ability to communicate with all levels of staff and a diverse range of members, providers, and stakeholders. This role must have excellent problem-solving and analytical skills. This role must also be familiar with Nebraska's BH priorities and have knowledge of the State's mental health system, including any current gaps, pending legislation, or court orders that may influence access to care. The Behavioral Health Clinical Director will also collaborate with community mental health centers and BH providers across the State to understand and address BH care gaps.

Education:

- Must be a currently practicing psychiatrist or psychologist with an unrestricted license in Nebraska
- Must also be board-certified in a specialty recognized by the American Board of Medical Specialists

Position Title: Behavioral Health Manager

Job Description:
The Behavioral Health Manager is responsible for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness, and/or with substance use disorders in compliance with federal and State laws and the requirements set forth in the contract. This job is required to be based in Nebraska.

Responsibilities include:

- Assists in the development and implementation of comprehensive case management programs for Nebraska Heritage Health
- Advocates for members and their families to assure their needs and choices are fully represented and supported by the BH team in a timely and appropriate manner
- Influences and assists corporate leadership in development of strategies and plans to achieve desired BH outcomes
- Assists the Community Engagement and Provider Services teams in providing a BH perspective for meetings and events with community organizations, provider groups, and advisory councils

Qualifications:

Experience:

- Minimum of seven years of experience in managing BH care operations
- Demonstrated ability to manage large scale, highly visible programs with responsibility for multiple teams
- Experience in problem solving and consultation within complex environments

Education:

- Master of Science in social work, counseling, psychology or related BH field or a degree in nursing
- Unrestricted Licensed Mental Health Professional

Position Title: Chief Operating Officer (COO)

Job Description:
Our full-time COO is responsible for managing the day-to-day operations of Healthy Blue's departments, staff, and functions to assure that performance measures and MLTC and federal requirements are met. The COO and may also serve as the primary contact with MLTC for all operational issues. They will work in tandem with the CEO in the fiscal and operational management of our organization. In this role, the COO provides key input and assists in developing and driving the strategic vision, goals, objectives, policies, and decision-making for our Heritage Health programs and services. The COO will also be proactive in leading strategic discussions among partners, including DHHS, Healthy Blue partners, and community stakeholders, to execute on collaborative statewide strategies. This job is required to be based in Nebraska.

Our COO maintains responsibility for the effective and efficient operations of Healthy Blue, with responsibilities that include:

- Collaborates internally with staff across departments to identify gaps and improve processes when needed
- Identifies and adopts operational best practices and metrics to achieve strategic goals and provide timely reports on operational progress and milestones to DHHS
- Creates seamless processes between our local Healthy Blue operations and the national shared support services that augment our programs and services
- Develops and implements key operational indicators to be used for monitoring and analyzing our operations
- Oversees development and delivery of a comprehensive set of custom reports for DHHS, including QM analytics and operational informatics to provide accountability and transparency to DHHS
- Serves as a liaison and builds relationships with providers, regulatory agencies, and stakeholders to help maximize the quality of programs and services we deliver
- Stays up-to-date on activities across our organization, including network development and provider experience, medical management, care management, QM, finance, and regulatory and compliance

Qualifications:

Experience:
The COO role requires at least 10 years of relevant experience, which includes nine years of in-depth managed care operations experience or any combination of education and experience that provides an equivalent background. The COO must have strong oral, written, and interpersonal communication and facilitation skills, along with the ability to analyze and problem solve. In addition, strategic thinking and project management skills are a plus along with capabilities to analyze and evaluate data to support meaningful decision-making. Strong understanding of operational requirements of the Heritage Health programs is required.

The COO must have extensive local knowledge and understanding of the populations and communities in Nebraska to help drive our Healthy Blue operations. This position must have knowledge of DHHS' Managed Care Quality Strategy with the ability to integrate it into management and operational practices. The COO must understand the Nebraska legislative process.

Education:
Bachelor's degree in relevant area of study; master's degree preferred

Position Title: Chief Financial Officer (CFO)

Job Description:
Our full-time CFO is responsible for overseeing all financial-related supervision of activities implemented by Healthy Blue, including all audit activities, accounting systems, financial reporting, and budgeting, as well as working with key leadership on strategic financial decisions and making sure we meet all contract requirements for financial performance and reporting. This role also develops financial contracts, interfaces, and processes to assure fiscal integrity and oversees the measurement and benchmarking of financial trends. This job is required to be based in Nebraska.

Our CFO maintains responsibility for fiscal operations and fiscal accountability, with responsibilities that include the following:

- Directs the overall budget, forecast, and cost-allocation processes, providing senior leadership with insights to maximize investment of resources
- Acts as a financial liaison for DHHS
- Maintains responsibility for achieving medical cost and Medical Loss Ratio targets
- Reviews provider contracts to help assure appropriate financial arrangements are in place
- Oversees the establishment of cost of care targets and remains accountable for achieving operating gain targets set in budgets and forecasts
- Serves as a subject matter expert on financial reimbursement policies and payment mechanisms
- Analyzes, reviews, reports, and presents on financial performance with key leadership
- Collaborates with Healthy Blue leadership to assure focus on current results versus budget, current financial performance trends, and the identification and implementation of strategies to manage review, medical, and gross margin
- Interfaces with regulatory and audit personnel to assure fiscal accountability

Qualifications:

Experience:
The CFO must have eight to 10 years of progressive financial experience in accounting, financial reporting, business analysis, budgeting, forecasting, and strategic and tactical planning within a health insurance/managed care environment. The role must also have experience working in complex business environments that include multiple entities and highly regulated operations, or any combination of education and experience that would provide an equivalent background.

To assure the fiscal health of our Nebraska operations, the CFO must be well versed in statistical/financial tools and modeling, possessing strong leadership and communication skills as well as problem-solving, facilitation, and analytical capabilities. The role must also be highly proficient in the Microsoft Office Suite (Excel, PowerPoint, Outlook) and be adept at understanding managed care, growth, and risks to provide forecasts and strategic recommendations.

Additional desired qualifications include an understanding of the annual rate-setting process for the Heritage Health programs. The CFO will be expected to work in collaboration with DHHS and State actuaries to review financial data and understand cost trends. The CFO will be expected to have knowledge of and experience with monitoring quality performance measures and value-based purchasing (VBP) as it relates to quality withholds.

Education:
Bachelor’s degree in relevant area of study; master’s degree preferred

Position Title: Program Integrity Officer

Job Description:
Our full-time Program Integrity Officer has detailed technical knowledge of claims payment accuracy and participates on cross-functional teams focused on problem remediation and long-term resolution. This job is required to be based in Nebraska. The Program Integrity Officer reports directly to the CEO and is responsible for:

- 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
- Developing/overseeing methods to prevent and detect potential FWA and erroneous payments
- Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans
- Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies
- Managing the Healthy Blue's SIU to communicate with the State's Medicaid Fraud Control Unit
- Serving as the primary point of contact for MLTC Program Integrity
- Anticipates the effect of changes in the business environment on future claim errors
- Evaluates regulatory compliance and health care reform changes to determine potential impact
- Evaluates provider activities to assist in the detection of FWA activities
- Monitors provisions of the compliance plan, including FWA policies and procedures
- Develops and analyzes monthly reports
- Develops project plans and oversees project execution, issue management, and progress reporting
- Develops processes to support early detection of systemic issues causing operational inefficiencies

Qualifications:

Experience:
The Program Integrity Officer must have experience in health care and/or risk management. More than eight years of experience with operations, financial reporting, and analysis, audit guidelines, budgeting, and multi-state operations and processes is required, as well as experience with complex business environments including multiple entity and highly automated situations. Five years of management experience is required or any combination of education and experience which would provide an equivalent background. Managed care experience is strongly preferred.

The role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Education:
Bachelor's degree in relevant area of study; master's degree preferred

Position Title: Grievance System Manager

Job Description:
Our full-time Grievance System Manager is responsible for managing/adjudicating member grievances, appeals, and requests for fair hearing and managing/adjudicating provider grievances and appeals. This role is responsible for reviewing, analyzing, and processing grievances and appeals to meet contract requirements and help assure timely resolution for members and providers. This job is required to be based in Nebraska. The Grievance System Manager's responsibilities also include:

- Uses guidelines and review tools to conduct extensive research and analyze the grievance and appeal issue(s) and pertinent claims and medical records to either approve or summarize and route to nursing and/or medical staff for review
- Prepares files for internal and external review by analysts, medical staff, or outside consultants and triages clinical and non-clinical inquiries, grievances, and appeals
- Prepares case files for committees/hearings and summarizes essential information for the Medical Director/Chief Medical Officer and legal counsel
- Tracks and prepares reports and trends on grievances and appeals to inform our quality initiatives and reporting to DHHS

Qualifications:

Experience:
The Grievance System Manager must have at least three to five years of experience working in grievances and appeals, claims, or customer service, or any combination of education and experience that would provide an equivalent background. This role requires strong oral, written, and interpersonal communication skills, as well as problem-solving, facilitation, and analytical skills. The role also requires an understanding of managed care principles.

Education:
Requires a high school diploma or equivalent; associate degree preferred

Position Title: Business Continuity Planning and Emergency Coordinator

Job Description:
The Business Continuity Planning and Emergency Coordinator is responsible for assuring continuity of benefits and services for members who may experience evacuation to other areas of the state, or out-of-state, during disasters. Responsibilities include:

- Updates and maintains our Business Continuity and Disaster Recovery Plan
- Manages and oversees Healthy Blue's Emergency Management Plan
- Coordinates continuity activities during emergencies
- Interfaces with all departments on business continuity and disaster recovery planning and execution

Qualifications:

Experience:
Training and seven years of experience in managed care with a focus on infrastructure, security, business continuity planning, disaster recovery, compliance, and delivery to drive quality results is preferred.

Education:
Bachelor's degree in relevant area of study; master's degree preferred

Position Title: Contract Compliance Officer

Job Description:
Our full-time Contract Compliance Officer will be the primary contact with MLTC on all Healthy Blue contract compliance issues and will report directly to the CEO. This individual is responsible for overseeing all activities required by the contract, State and federal rules and regulations related to the coordination, preparation, and execution of contract requirements, coordinating the tracking and submission of all contract deliverables, answering inquiries from MLTC, and coordinating/performing random and periodic audits and ad hoc visits. This job is required to be based in Nebraska.

The Contract Compliance Officer will be primarily responsible for designing, implementing, and overseeing policies and programs to maintain compliance with the contract and all applicable State and federal rules and regulations. Additional responsibilities include the following:

- Monitors compliance standards and stays up-to-date on the latest requirements and regulations that impact Heritage Health programs
- Reviews and maintains accountability for the completeness, accuracy, and timeliness of reporting and data submissions to DHHS
- Evaluates existing policies and procedures to coordinate internal practices and confirm continuous compliance
- Develops the annual Compliance Plan and oversees program integrity for the organization, which includes directing initiatives pertaining to risk assessments, audits, training, and readiness
- Leads compliance monitoring to identify process gaps, validate compliance levels, map processes, draft corrective actions/remediation plans, oversee implementation of corrective actions, and prepare reports/presentations
- Manages complex investigations and documents findings related to compliance and program integrity

Qualifications:

Experience:
The Contract Compliance Officer must have eight to 10 years of health care, regulatory, ethics, compliance, or privacy experience, or any combination of education and experience that would provide an equivalent background. This role must develop strong relationships with key leaders to identify and address compliance risks and failures and manage action plans designed to fully mitigate risk(s). Must have strong leadership/managerial skills and ability to motivate/coach other staff.

The Contract Compliance Officer must have extensive knowledge of Heritage Health program requirements, along with a background in Medicaid and managed care. The Contract Compliance Officer must have knowledge of State and federal Medicaid requirements as it relates to Healthy Blue functions in areas such as, but not limited to, operations and quality. Knowledge of the Medicaid Managed Care Quality Strategy would be beneficial for this role.

Education:
Bachelor’s degree in relevant area of study; master’s or Juris Doctor preferred

Position Title: Quality Management Coordinator

Job Description:
Our full-time Quality Management Coordinator is responsible for assuring systemic and individual quality of care, identifying and implementing process improvements, integrating quality throughout the organization, assuring a network of credentialed providers, resolving, tracking, and trending quality of care grievances, and serving as a member of the Quality Assurance Performance Improvement Committee and member/ad hoc member of other quality-related committees. This job is required to be based in Nebraska.

The Quality Management Coordinator drives the development, coordination, communication, and implementation of our clinical quality initiatives to help assure our members receive the best services and supports to address their needs. The role's responsibilities include the following:

- Coordinates our QM team staff and their activities, including monitoring and auditing our health care delivery system (including internal processes and procedures, service quality, and clinical quality)
- Coordinates all aspects of our annual QM program, including performance improvement projects, workplans, and annual evaluations
- Works collaboratively with our parent company's regional head of QM to implement best practices and coordinate HEDIS and CAHPS® reporting and measures
- Serves as a key contributor and leader on the Population Health Council to inform and develop strategies to address health disparities across Nebraska communities
- Collaborates with other departments in developing, monitoring, and evaluating HEDIS improvement action plans and year-round medical record reviews
- Monitors and reports quality measures and accrediting requirements for DHHS and CMS
- Assists the Contract Compliance Officer in coordinating our operations to meet DHHS' goals of improving the health outcomes of members in Nebraska
- Facilitates a multi-disciplinary approach to resolving issues and improving processes
- Coordinates our organization's performance and fosters participation across departments in performance improvement initiatives to share and learn best practices

Qualifications:

Experience:
This position is 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.

The Quality Management Coordinator must have at least five years of experience in a health care environment or any combination of education and experience, which would provide an equivalent background. Clinical program development and implementation experience is preferred, along with experience coordinating rapid-cycle improvement techniques that demonstrate material improvements.

This position must have demonstrated skills in QI concepts, health care data analysis, and data-mining methods. The role must have practical knowledge of the tools and techniques for continuous QI, including the ability to analyze and interpret data to identify population trends, issues, and health disparities that exist in Nebraska.

Education:

- Bachelor's degree in a clinical or health care field (for example, nursing, epidemiology, health sciences); master's degree preferred
- State-licensed registered nurse, physician, or physician's assistant
- 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

Position Title: Performance and Quality Improvement Coordinator

Job Description:
Our full-time Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include focusing organizational efforts on the improvement of clinical quality performance measures, using data to develop intervention strategies to improve outcomes, developing and implementing performance improvement projects, both internal and across MCOs, and reporting QI and performance outcomes to MLTC. This job is required to be based in Nebraska.

The Performance and Quality Improvement Coordinator's additional responsibilities are:

- Assures integration of quality into the overall business process
- Performs assessments to identify gaps in the enterprise's quality and technology assessment processes and initiates actions to correct these gaps
- Assures accuracy and completeness of input provided to internal and external QI Committees and timely implementation of appropriate interventions
- Oversees the clinical QI activities/projects to implement appropriate clinical interventions to improve the quality of care for members
- Assures compliance with corporate QI work plans
- Assures QI activities are relevant to the targeted population
- Assures compliance with practice guideline, delegation, and continuity and coordination of care standards

Qualifications:

Experience:
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 role requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Education:

- Associate or bachelor's degree in relevant area of study; master's degree preferred
- CPHQ or CHCQM preferred

Position Title: Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator

Job Description:

The Maternal Child Health/Early and Periodic Screening, Diagnostic, and Treatment Coordinator (MCH/EPSDT Coordinator) is responsible for designing programs to assure that all member children receive necessary EPSDT services, promoting family planning services, promoting preventive health strategies, designing programs to assure that all pregnant members receive maternal and postpartum care, identifying and coordinating assistance for identified member needs, specific to maternal/child health and EPSDT, and interfacing with community partners. The MCH/EPSDT Coordinator will oversee the MCH/EPSDT program including strategy, data analysis, and development of QI activities. This position will track outcomes and use the Plan-Do-Study-Act model for continued QI. This job is required to be based in Nebraska.

Additional MCH/EPSDT Coordinator responsibilities include:

- Assures integration of quality into the overall business process
- Performs assessments to identify gaps in the enterprise's quality and technology assessment processes and initiates actions to correct these gaps
- Assures accuracy and completeness of input provided to internal and external QI Committees and timely implementation of appropriate interventions. Oversees the clinical QI activities/projects to implement appropriate clinical interventions to improve the quality of care for members
- Assures compliance with corporate QI workplans
- Assures QI activities are relevant to the targeted population
- Assures compliance to practice guideline, delegation, and continuity and coordination of care standards

Qualifications:

Experience:

This role requires three years of health care quality or data analysis experience (or any combination of education and experience that provides an equivalent background). The role also requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Education:

- Associate or bachelor's degree in relevant area of study; master's degree preferred
- Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Nebraska license; Bachelor of Science in Nursing and CPHQ and prior project management experience is preferred

Position Title: Medical Management Coordinator

Job Description:
Our full-time Nebraska-licensed Medical Management Coordinator works in collaboration with our Medical Director/Chief Medical Officer and integrated medical management team to provide UM activities guided by Nebraska-specific policies and procedures and nationally recognized best practices. This job is required to be based in Nebraska.

The Medical Management Coordinator's responsibilities include:

- Developing, implementing, and monitoring the provision of care coordination, Disease Management (DM), and case management functions
- Assuring the adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Assuring the completion of appropriate concurrent review and discharge planning of inpatient stays
- Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services
- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards
- Uses clinical knowledge, communication skills, and critical thinking to interpret criteria, policies, and procedures that provide the best and most appropriate treatment and services for members
- Participates on key committees, including the Health Equity Advisory Council and the Clinical Services Committee
- Assures program compliance and identifies opportunities to improve members' experience and quality outcomes
- Oversees the development and execution of medical and case management policies, procedures, and guidelines
- Assists in developing clinical management guidelines
- Verifies that medical management activities are contracted, reviewed, and reported
- Supports quality initiatives and activities, including clinical indicators reporting, focus studies, and HEDIS reporting

Qualifications:

Experience:
The Medical Management Coordinator must have a minimum of five years of clinical experience, including prior management experience, or any combination of education and experience that would provide an equivalent background. NCQA accreditation and HEDIS reporting experience are also preferred. This role must have strong oral, written, and interpersonal communication skills, as well as problem-solving, facilitation, and analytical skills.

The Medical Management Coordinator must also have knowledge of clinical practice guidelines, as well as care management, care coordination, and utilization review processes, and an understanding or background with vulnerable populations, including Nebraska Medicaid and CHIP members. Our Medical Management Coordinator must also have knowledge across care settings (inpatient, outpatient, emergency services, home health, and public health) plus experience assuring smooth transitions between levels of care with minimal to no disruption in appropriate medical services.

Education:

- Requires a bachelor's degree in a health care field; master's degree in a health care field or MBA with health care concentration preferred
- Nebraska-licensed registered nurse, physician, or physician's assistant if they are 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

Position Title: Dental Management Coordinator

Job Description:

The Dental Management Coordinator's responsibilities include:

- Developing, implementing, and monitoring the provision of care coordination, DM, and case management functions
- Assuring the adoption and consistent application of appropriate dental services medical necessity criteria
- Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services
- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards

Qualifications:

Experience:

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.

Education:

Requires a master's degree in health services, health care administration, or business administration

Position Title: Provider Services Manager

Job Description:
The full-time Provider Services Manager oversees all operations related to the Provider Services call center and our Provider Services department, making sure all providers are equipped with the information and resources they need to best serve members. This role oversees initiatives and programs focused on provider education, contract compliance, and maximizing provider satisfaction while minimizing administrative burdens. The Provider Services Manager directs the communication and complaint resolution strategies between physicians, hospitals, members, and the public. This job is required to be based in Nebraska.

Responsibilities include:

- Coordinating communications between Healthy Blue and our subcontracted providers
- Managing the Provider Services staff
- Working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns
- Developing provider training in response to identified needs or changes in protocols, processes, and forms
- Enhancing Healthy Blue-provider communication strategies
- Notifying MLTC of correspondence sent to providers for informational and training purposes
- Participating in the MLTC Administrative Simplification Committee
- Supervises and fosters a team of professionals dedicated to supporting providers
- Maintains responsibility for hiring, training, coaching, counseling, and evaluating the Provider Services team of employees, including our Provider Services Representatives
- Oversees the Provider Services department budget, which includes funding for developing and maintaining a comprehensive network of providers
- Maintains responsibility for assuring that our Provider Services-related operations comply with all terms and requirements of the contract
- Achieves individual and team performance goals/metrics
- Leads Provider Advisory Group meetings with external providers to secure valuable and actionable feedback on initiatives
- Oversees coordination with the Central Credentialing Verification Subcontractor (CCVS)
- Develops and implements provider education initiatives and manages the development, updates, and distribution of our provider handbook and other outreach and education programs
- Works in conjunction with our Patient-Centered Medical Home (PCMH) Transformation Consultants and Health Equity Director to identify and recruit new provider practices into the PCMH program

Qualifications:

Experience:
The Provider Services Manager must have eight or more years of experience with contracting and network development, including implementation of VBP agreements and supporting implementation of these. The role must also have working knowledge in the areas of practice management, long-term acute care, home health, home infusion, BH, and ambulatory surgery; outpatient experience is preferred. Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

This position supports and educates providers on how to meet and exceed quality metrics for VBP. Thus, the role must have the ability to follow reimbursement as directed by DHHS and follow appropriate reimbursement methodologies found in the DHHS fee schedule, provider billing manual, and State plan or administrative code.

Education:
Bachelor’s degree in relevant area of study; master’s degree preferred

Position Title: Member Services Manager

Job Description:
The full-time Member Services Manager manages Member Services functions, including call center operations, and is accountable for meeting all contract requirements and performance standards. This job is required to be based in Nebraska. The Member Services Manager oversees the day-to-day operations of Member Services, including the following responsibilities:

- Coordinating communications between Healthy Blue and our members
- Assuring that there are sufficient Member Services Representatives and 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
- Managing the Member Services staff
- Maintains compliance with all operational requirements of the contract
- Develops and implements Member Services and outreach programs designed to reach all members across the State and assure they have the information they need to access covered services and benefits
- Produces daily, weekly, and monthly reports, as well as ad hoc reports to monitor performance and member inquiries and requests (to identify trends and resolutions as needed)
- Manages and confirms that Member Services staff are following established policies, guidelines, and scripts, and are meeting quality standards

Qualifications:

Experience:
The Member Services Manager must have a minimum of three years of experience leading and managing teams, plus five years of related customer service experience. In addition, the role must demonstrate knowledge and experience in operational analyses, processes, and performance indicators. The role requires exceptional leadership and oral, written, and interpersonal communication skills. This includes a keen ability to understand our members in Nebraska and build relationships. The role must also possess problem-solving, facilitation, and analytical skills.

To be culturally responsive to members and address their needs effectively, our Member Services Manager must have knowledge of the state's geography, communities, and the diverse populations we will serve through the Heritage Health programs. Prior experience working with a vulnerable population and knowledge of benefits in the Heritage Health programs will be beneficial.

Education:
High school diploma or equivalent; associate degree preferred

Position Title: Claims Administrator

Job Description:
The Claims Administrator oversees claims processing and adjudication, making sure claims are paid timely and accurate, and in accordance with contract requirements. Responsibilities include:

- 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
- Developing cost avoidance processes
- Meeting claims processing timelines
- Assuring minimization of claims recoupments
- Meeting MLTC encounter reporting requirements
- Managing the development and refinement of claims administration in accordance with State and federal regulations
- Overseeing the full cycle of claims-process automation and identifying and leveraging data and technology to improve quality and maintain cost-effectiveness
- Performing root cause and audits of claims projects to determine trends and subsequently make recommendations for actions
- Maintaining accountability for coordination of benefits program and policies to optimize payment accuracy
- Creating innovative solutions to automate processes and build reports, dashboards, and metrics to provide actionable insights on claims-handling and payment processes
- Overseeing internal and external claims communication, making sure claims issues are handled professionally and timely

Qualifications:

Experience:
The Claims Administrator must have three to five years of claims operations and technical knowledge of claims systems.

This role requires strong analytical skills and attention to detail, as well as communication, facilitation, and problem-solving skills. The Claims Administrator must also have knowledge of medical codes as well as an understanding of managed care principles, end-to-end claims cycle, and Heritage Health covered benefits, services, and reimbursement.

Education:
Requires a high school diploma or GE; bachelor's degree preferred

Position Title: Provider Claims Educator

Job Description:

The Provider Claims Educator is responsible for:

- Educating in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available Healthy Blue resources, such as provider manuals, websites, provider training materials, and fee schedules
- Communicating frequently with providers to assure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction
- Working with Healthy Blue's call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements

Qualifications:

Experience:

The Provider Claims Educator must be knowledgeable concerning Healthy Blue'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 years management and supervisory experience in a health care field.

Education:

Requires a high school diploma or GE; bachelor's degree preferred

Position Title: Case Management Administrator

Job Description:
The full-time Nebraska-licensed Case Management Administrator oversees our case management services and the Case Management staff who support members, including Care Managers, Case Managers, Care Coordinators, and Community Health Workers (CHWs).The Case Management Administrator is responsible for overseeing Healthy Blue's case management functions; working with other staff to assure that members' case management needs are met; and working with the Medical Director/Chief Medical Officer and other medical management staff to assure that Healthy Blue's case management policies/protocols comply with federal and State requirements. This job is required to be based in Nebraska.

The Case Management Administrator leads the Case Management team in addressing members' needs, helping them navigate the health care system and maximizing the use of benefits and services available to achieve the best outcomes. Responsibilities include the following:

- Provides leadership over the administration of day-to-day case management services, leveraging knowledge of processes, programs, systems, and data to provide oversight
- Oversees case management processes and policies to make sure they continuously meet contract requirements and meet quality of care standards
- Gathers and interprets data and metrics to optimize case management services
- Serves as an advocate for our members, making sure we have the information and supports in place to help guide them through the health care system
- Supervises the Case Management team and helps coach them in the care coordination process, facilitating a multi-disciplinary approach among all parties involved in care (member, family, friends, providers, caregivers, etc.)
- Maintains responsibility for the development and accuracy of case management reports as required by the contract
- Identifies and addresses gaps and barriers in case management services in conjunction with clinical leadership
- Makes decisions related to identifying and resolving complex technical and operational issues within case management and leads the Case Management team of highly specialized professionals in outreach and support initiatives designed to maximize member health and well-being

Qualifications:

Experience:
The Case Management Administrator must have experience as a Case Manager with a minimum of five years management or supervisory experience in a health care field. This role requires strong leadership and clinical knowledge, as well as exceptional communication, problem-solving, facilitation, and analytical skills.

The Case Management Administrator should also have knowledge and experience working with Nebraska community organizations and State agencies, as well as a background serving members in the State who have complex needs that require case management services. The role must also keenly understand the closed-loop referral process, CHW model, and PCMHs.

Education:

- Associate or bachelor's degree in relevant area of study; master's degree preferred
- Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC, or another accepted Nebraska license; Certified Case Manager Certification preferred

Position Title: Information Management and Systems Director

Job Description:

The Information Management and Systems Director oversees all Healthy Blue information systems functions and is responsible for:

- Establishing and maintaining connectivity with MLTC information systems
- Providing necessary and timely data and reports to MLTC
- Analyzing information technology solutions and working in tandem with vendors on implementations, upgrades, and issue resolution
- Updating and maintaining our Business Continuity and Disaster Recovery Plan
- Developing and overseeing a Technology Plan and Forecast to assess tools, applications, and infrastructure across functional areas to make sure we are providing member-focused, integrated technologies that help us improve outcomes
- Functioning as single point of contact for business and IT partners
- Coordinating and leading multiple teams on initiating, developing, designing, and implementing new change initiatives
- Directing, reviewing, and approving communications and leading meetings with area lead contacts to gather needs and issues
- Working in collaboration with our Claims Administrator and Data and Analytics Manager to assure the encounter data system is configured appropriately to generate submissions that meet all Heritage Health contract requirements
- Monitoring the reconciliation process, providing oversight to assure completeness, accuracy, timeliness metrics, and correction
- Acting as a liaison to leverage technology initiatives and best practices from affiliates and interfacing with the national Encounters team
- Executing appropriate business associate agreements, reviewing and authorizing all cloud access requests submitted by DHHS staff, and verifying the identity of users prior to granting credentials

Qualifications:

Experience:

The Information Management and Systems Director must have relevant training and a minimum of seven years of experience in information systems, data processing, and data reporting. This role must have broad Medicaid industry and technology knowledge, including cloud technologies, automation preferred. Experience interacting directly with State and federal regulatory agencies is also preferred. Experience crafting or contributing to technology strategy preferred.

This role must have exceptional technical knowledge and skills to champion technology that improves the experience of our members and providers. In addition, the Information Management and Systems Director must have a strong understanding of portfolio management methodology, tools, and processes. This role must have detailed knowledge of DHHS IT procurement and CMS IT approval and certification and extensive understanding of the contract reporting and data exchange requirements. Experience in managed care with a focus on infrastructure, security, compliance, and delivery to drive quality results is also preferred.

Education:

Bachelor’s degree in relevant area of study; master’s degree preferred

Position Title: Encounter Data Quality Coordinator

Job Description:
The Encounter Data Quality Coordinator is responsible for end-to-end encounter data management operations, verifying timely and accurate reports and member encounter data to DHHS. Responsibilities include:

- Organizing and coordinating services and communication between Healthy Blue administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues
- Serving as Healthy Blue's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions
- Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output
- Analyzing complex encounter process issues (both inbound and external), using data from a variety of internal and external sources to provide insight that supports decision-making
- Working in conjunction with the national Encounters team, which supports sharing best practices and lessons learned to help assure overall encounter data compliance
- Monitoring encounter processes, submission requirements, and performance metrics to help assure we continuously meet all contract requirements related to encounter data
- Conducts root cause analyses of claims/encounters processing and submission to identify and resolve issues as quickly as possible
- Verifies the encounter process to verify rigorous validation of data accuracy from claim adjudication through encounter file creation
- Works collaboratively across departments to design and implement system changes to meet encounter data processing and submission standards and goals
- Develops and disseminates reports to appropriate department leads for error resolution, follow-up, and performance monitoring
- Participates in a workgroup to identify and promptly resolve data and process issues across the organization

Qualifications:

Experience:
Three to five years related experience is required in an actuarial environment performing financial reporting, rate development, evaluation of risk contingencies and trend projections; or any combination of education and experience that would provide an equivalent background.

The role requires strong problem-solving, facilitation, and analytical skills. This role also must have knowledge of Nebraska Medicaid and CHIP reimbursement methodology, along with experience with CMS-required reporting. Prior experience with Nebraska fee-for-service and managed care claims adjudication processes is also needed.

Education:
Requires a high school diploma or GE; bachelor's degree preferred.

Position Title: Tribal Network Liaison

Job Description:
The Tribal Network Liaison serves as the single point of contact with Tribal entities and all Healthy Blue staff on American Indian issues and concerns. This job is required to be based in Nebraska. Responsibilities include:

- Planning and working with Provider Services staff to expand and enhance physical, BH, and dental services for American Indian members
- Advocating for American Indian members with Case Management and Member Services staff
- Overseeing the development of policies and procedures for care and case management for Tribal members and those who are eligible for care through Indian Health Service (IHS) or other Tribally funded Health and Human Services programs, including:
  - Identification and appointment of a Tribal Liaison to work with IHS and the Tribes
  - Development of processes and procedures to identify, assure appropriate access to, and monitor the availability and provision of culturally appropriate care within Healthy Blue's network
  - Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally operated facility/program, and Urban Indian Clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638
  - Development of methods for regularly coordinating on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Health Centers, and other involved agencies to coordinate and facilitate health service delivery

Qualifications:

Experience:
The role requires strong oral, written, and interpersonal communication skills, including the ability to develop a collaborative relationship with IHS and Tribal organizations. The role must also possess a minimum of five years of customer service experience including two years of provider experience; or any combination of education and experience, which would provide an equivalent background.

Education:
Requires a high school diploma or GE; bachelor's degree preferred

Position Title: Pharmacist/Pharmacy Director

Job Description:
Our full-time Nebraska-licensed Pharmacy Director is responsible for coordinating all pharmacy services and related reporting. This position serves as the primary contact for our pharmacy services. This job is required to be based in Nebraska.

Responsibilities include:

- Overseeing prescription drug and pharmacy benefits
- Leading and coordinating formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving
- Consulting on and coordinating pharmacy program changes
- Understanding clinical pharmacy and drug product information to support plan benefit design in the point of sale (POS) system
- Overseeing, monitoring, and assisting with the management of Pharmacy Benefits Manager (PBM) activities
- Managing prospective and retrospective drug utilization review (DUR) activities
- Supporting call center prior authorization programs and their development/modification
- Attending MLTC Pharmacy and Therapeutics Committee and DUR Board meetings
- Meeting with MLTC staff and Healthy Blue's PBM, no less than monthly, to discuss operational status updates, including the call center, POS system, grievances, and prior authorizations, as well as review performance standards and restricted services grievances and appeals
- Developing and implementing clinical pharmacy program initiatives and processes to promote quality and cost-effective drug utilization
- Working collaboratively with DHHS' PBM in all aspects of pharmacy administration and services, including making sure there are no disruptions in a member's medication for those transitioning to or from another contractor
- Monitoring DHHS' preferred drug list (PDL) and working with providers and Care Managers on changes to the PDL that may impact members' prescribed medications
- Overseeing clinical pharmacy operations and staff to make sure all related contract deliverables are met, and maintaining policies and processes, training, and communication related to pharmacy services
- Providing guidance related to member medications during multi-disciplinary rounds and serving as liaison with the PBM for medication coverage and prescription fulfillment issues
- Developing pharmacy programs in conjunction with the PBM to address polypharmacy and other issues impacting Nebraska
- Managing both internal and external stakeholder communications for pharmacy
- Maintaining responsibility for making sure the required drug utilization reports are submitted accurately and punctually to DHHS weekly and resolving any disputes related to the data within 30 calendar days from notification by DHHS

Qualifications:

Experience:
The Pharmacy Director must have three to five years of managed care pharmacy experience, including knowledge of current health care and managed care pharmacy practices (or any combination of education and experience that would provide an equivalent background). The role must also have advanced knowledge of pharmacy programs, policies, and procedures across Medicaid MCO operations, including UM, QM, and pharmaceutical requirements.

The role requires strong oral, written, and interpersonal communication skills, including the ability to develop a collaborative relationship with DHHS' PBA. The role must also possess problem-solving, facilitation, and analytical skills. The Pharmacist/Pharmacy Director must have knowledge of Heritage Health covered services and benefits, as well as the ability to evaluate scientific evidence and best practices to apply these principles to best serve our members. Extensive knowledge of medication therapies, treatment guidelines, and regulatory requirements is also preferred.

Education:

- Doctor of Pharmacy degree
- Registered pharmacist with a current Nebraska license

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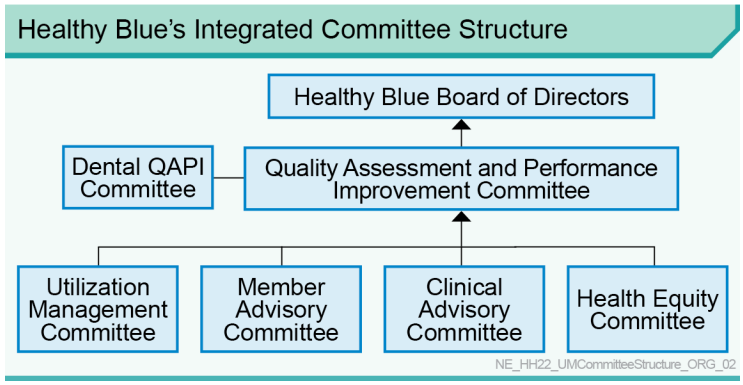
Delivering Physical Health, Behavioral Health, Dental, and Pharmacy Services

Our organizational structure supports a coordinated approach to optimally managing services for our members. Our Healthy Blue Chief Executive Officer (CEO), Dr. Robert Rhodes, drives the complete alignment and integration of all functional areas from clinical solutions, quality management, provider solutions, marketing, and operations. The Healthy Blue Quality and Clinical Committee structure supports the CEO by assuring every functional area collaborates in the integration and delivery of care, to include physical health (PH), behavioral health (BH), dental, pharmacy, and social supports and is held accountable for executing on our population health strategy and achieving MLTC's goals. This coordinated approach provides synergy among all health plan staff and alignment around key priorities so we can achieve our goals and outcomes with a focus on equity while creating a seamless experience for all members. All Healthy Blue staff receive training on integrated care that will also include dental benefits under the new contract.

Healthy Blue Committee Structures Driving Integrated Care

Healthy Blue's administrative structure and collaborative committees supporting service integration across the health plan are highlighted in Figure V.D.16-1.

Figure V.D.16-1. Healthy Blue Integrated Committees.



Quality Assessment and Performance Improvement Committee (QAPIC) and Workgroups Facilitate Interdepartmental Commitment to Quality Improvement. Supporting the QAPIC, subcommittees and health plan workgroups focus on driving quality improvements. The following committees and workgroups report to the QAPIC and inform the quality management (QM) program:

- **Clinical Advisory Committee (CAC).** Our CAC engages local PH and BH providers, as well as providers representing the types of services our members receive. It reviews and provides input on QM activities, claims trends, and other significant developments and approves clinical practice guidelines to confirm local Nebraska practice context; approves utilization management (UM) criteria, program evaluations, and descriptions; and reviews information about appeals, grievances, pharmacy updates and recalls, credentialing updates, and peer review for quality of care issues. The CAC conducts peer reviews to assess provider quality of care issues and discusses plans of action. The committee also monitors practice patterns and drug utilization to verify appropriateness of care as well as improvement and risk prevention activities, including review of clinical studies, development and approval of action plans, and recommendations for quality improvement (QI) studies. Members include our Chief Medical Officer; BH Clinical Director; Dental Director; QM leaders; and seven network providers, including three psychiatrists, one internal medicine physician, one OB-GYN, one family nurse practitioner, and three family medicine physicians.
- **UM Committee (UMC).** Chaired by our Chief Medical Officer and our Case Management Administrator, our UMC oversees all UM and social determinants of health (SDOH) program activities and processes, including delegated clinical services. The committee reviews, monitors, and evaluates UM program compliance with Healthy Blue standards, State and federal laws and regulations, contractual requirements, and NCQA standards. The UMC reviews the annual UM and population health management program descriptions and work plans; assesses the program's overall effectiveness, including long-term inpatient stays; monitors grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities for recommendations; and focuses on both PH and BH continuity of care.
- **Health Equity Committee.** Led by the Health Equity Director, this committee includes participants representing members, advocates, providers, and representatives of community organizations to inform and guide our efforts to create a more equitable health care experience. The Taskforce will also focus on rural area disparities to improve quality of care and reduce health disparities for members in underserved areas.
- **Member Advisory Committee.** Promotes a collaborative effort to enhance the MCO's patient-centered service delivery system. Its purpose is to provide input and advice regarding the MCO's program and policies.
- **Dental QAPI Committee.** Chaired by our Dental Director, this committee promotes a collaborative effort from health plan leadership, members, and providers to direct and review QI activities and assure the Dental QAPI activities are implemented, track and analyze data, define goals and key performance indicators, and provide strategic direction and oversight.

Continuity and Coordination of Physical Health, Behavioral Health, Dental, and Pharmacy Services

The activities described in Table V.D.16-1 stress the collaboration between physical, behavioral, dental, and pharmacy service practitioners and support whole-person care. Members with co-occurring PH and BH conditions are at risk for increased hospitalizations and increased cost of care.

Healthy Blue has developed evidence-based utilization review criteria to guide both providers and concurrent reviewers to the most appropriate level of care. We minimized prior authorization requirements for most outpatient, community-based services for BH and comorbid conditions. Healthy Blue continually monitors best practices and improvements in the management of co-occurring conditions and regularly modifies clinical criteria and guidelines to reflect these changes.

Through systematic data collection and analysis, opportunities for improvement are identified and activities are undertaken to improve the continuity and coordination of medical and BH care for members.

The Pharmacy team performs monthly claims surveillance and refers members to care management based on claim anomalies, medication gaps and over- and under-utilization of medications. The Care Management team seamlessly picks up and acts on the referrals, working with the member and their providers to assure members' immediate needs are taken care of and chronic disease states are effectively managed.

For example, after taking notice of a member's claims frequency for the diabetic medication glucagon, our pharmacy claims surveillance team referred a member to a Care Manager (CM). The member had developed post-gastric surgery hypoglycemia, but her prior endocrinologist would not respond to her calls. The CM facilitated a prompt appointment with a new endocrinologist, who performed tests to confirm the prior diagnosis. The doctor then prescribed a blood sugar monitoring device and a new medication. The member soon reported a cessation of the fainting spells and disorientation from blood sugar fluctuations, along with a greatly improved quality of life for both her and her family. The combined efforts of proactive pharmacy claims monitoring and the Care Management team resulted in the best possible outcome for this member.

Table V.D.16-1 provides a description of various organized integrated activities between multiple functional service areas.

Table V.D.16-1. Integrated Activities.

Integrated Activity Name	Description of Activity	Attendees
Clinical Rounds	Chief Medical Officer (CMO) and Behavioral Health Clinical Director lead PH CMs and BH CMs in discussion of difficult cases to problem-solve, teach to, and collaborate with the integrated team. The CMO and Behavioral Health Clinical Director also have a standing one-on-one meeting.	PH and BH Care Management and UM teams, Pharmacy team, Dental Director
Restricted Services	CMO, Behavioral Health Clinical Director, Pharmacy Director, Dental Director, and BH and PH Managers meet to review members flagged through pharmacy and prompt integrated interventions from both PH and BH Care Management teams.	Both PH and BH Managers, Pharmacy Director, Dental Director
HEDIS Task force	BH and PH leaders meet to address BH initiatives and how to move toward quality measures. The team works to develop and implement strategies to support both PH and BH measures for children and adults.	Quality Leads Initiative with BH/Care Management Managers and Pharmacy team, Dental Director
Child and Family Services (CFS) Collaboration	Meeting with CFS case managers and supervisory staff to address PH/BH needs of members on foster care file.	PH, Care Management, and Pharmacy Managers and Assigned Staff
UM Huddles	UM/Care Management Director, Pharmacy Manager, Dental Director, BH Manager, and Case Management Administrator meet to make sure that members avoid adverse impacts to their health condition, especially those with complexities that encompass both BH and PH. The interdisciplinary approach identifies members' needs in both UM and care management such as addressing services and care that may not be available at a member's current place of service/inpatient stay. A member in a hospital for a PH condition but with continued needs after discharge for BH, for example, would be presented during these meetings. We would discuss hand-offs between PH and BH, so that there are no breaks in service or lapse in care for a medical condition that requires continued care. Care management referrals would be made if needed to assure that the member and family's needs are also assessed and addressed.	PH/BH UM, Care Management, and Pharmacy, Dental Director
OB and NICU Rounds	BH support and collaboration for members that are in OB care management. BH works secondary to support any member identified that has BH concerns secondary to their pregnancy.	OB and NICU Care Management Leads Initiative
Integrated CM Team Meeting	BH/PH Managers, clinical leadership, and Care Management Leads meet to identify health plan needs and care management training.	BH/PH/Pharmacy Managers and Care Management Lead, Dental Director
Integrated CM Teams Channel	Virtual meeting place to share information, post QRGs, clarify information, needs, and ask questions on an ongoing basis.	BH/PH Case Management and Outreach Care Specialists, Dental Director, and Pharmacy teams
BH Team Huddles	This meeting brings together the BH Clinical Director, BH UM staff, and BH Care Management staff, with the PH manager and staff invited to attend as needed, to collaborate and coordinate services to high-risk members or rapid re-admit members.	BH/PH Managers, BH Medical Director, UM and Care Management and Pharmacy staff, Dental Director
Integrated Manager/ Director Meetings	Managers across both PH and BH meet weekly. The CMO and BH Medical Director attend to work together on variety of initiatives affecting both PH and BH members.	PH/BH/Pharmacy/Dental Directors and Managers
BH/PH Case Consultation	On an as-needed basis, our integrated team will use the expertise and experience of our Registered Nurses and Licensed Mental Health Clinicians on supporting each other in specific needs and for	BH/PH/Pharmacy/Dental teams

Integrated Activity Name	Description of Activity	Attendees
	ad hoc consultations to address all aspects of a member's care. This may include consulting on coordination of care such as post-discharge management, transitions of care from one level of service to another or transitioning from a primary PH provider to a primary BH provider (and vice versa). Other needs may include addressing community-specific resources, SDOH needs, and general support.	
All Plan Town Hall	Entire health plan gathering to discuss each departmental updates and resources.	All Departments
Foster Care Workgroup	Meeting with identified CMs and OCS and Leads to identify best practice care management for the foster care population.	BH/PH/Pharmacy/Dental CMs and Managers
Market Solutions Meetings	Enterprise meeting with representation from Nebraska health plan staff to identify unique market needs and best practices in integration of PH and BH.	BH/PH Manager and Pharmacy, Dental Director
Quad Meeting	Meetings with CMO, BH Clinical Director, Pharmacy Director, Dental Director, Quality Coordinator, and Health Care Management Services Director. Department leads review departmental goals, discuss barriers and solutions, collaboration sessions on initiatives.	CMO, Quality, BH, HCMS, Pharmacy, Dental Director
Ambassadors Meeting	Facilitates communications on a deeper, more granular level between leadership, management, and employees. Team meets and oversees quarterly market town halls, bi-monthly newsletter, and community volunteer opportunities.	All Healthy Blue Staff
Senior Staff Huddle	Attended by all department leaders. Run by CEO. Discuss employee updates, upcoming/previous meetings, functional status of each department, hot topics, and action plans.	Leaders from all Healthy Blue Departments
CM Provider Alignment	This project focuses on assisting markets with setting up care management rounds with identified providers (based on volume, relationship, need, etc.). We will pair a specific point of contact (CM) with each (or multiple) providers. Discussion of difficult to place (for example, from acute to post-acute) would occur during these rounds, and would assure safe discharges, set-up of safety at home, ease of transfer between facilities, etc. with a goal for an interdisciplinary approach for our members to receive treatment with no discontinuity and minimize interference with anticipated outcomes.	BH/PH/Pharmacy CMs

To support Healthy Blue's organizational structure, all Care and Utilization Managers use shared clinical platforms such as Health Intech and Member 360°$_{SM}$ and reports such as CI^3, ED reduction, and other claims-based reports. All Healthy Blue shared clinical platforms support improved coordination of care by providing our clinical teams clear insight and oversight of the full spectrum of service delivery and Member care. Although our CMs are the quarterbacks for Members and assure forward progress in all aspects in the provision of Member needed wrap-around services, they work collaboratively every day with other programs and departments to support members as a unified team. All CMs work together to co-manage each member to assure that all PH, BH, pharmacy, and dental needs are met. All CMs receive comprehensive training to equip them with a robust toolbox of skills and expertise.

The scope of our UM program includes activities related to emergency, inpatient and ambulatory care, pharmacy, and denial services, and collaborates with other internal programs for care coordination, discharge planning, and case management. It adopts an integrated medical management model based on the physical, behavioral, functional, and social needs of members identified in our needs-based assessment. The UM program, in collaboration with other programs such as disease management and case management, facilitates the delivery of the most appropriate medically necessary care, benefits, and services to eligible members in the most appropriate setting while promoting overall integration. In addition to collaboration with other Healthy Blue programs, we also coordinate UM processes with IngenioRx, our Pharmacy Benefits Manager, and Liberty Dental, our contracted Dental Benefits Manager.

Our parent company holds Population Health and full Managed Behavioral Health Organization accreditation, achieving a perfect score for all elements of the UM program and a High passing score on all file review elements. This reflects commitment to integration of PH and BH at the health plan and practice levels. Population Health Accreditation is awarded to organizations that monitor and address opportunities and challenges in population health and align their approaches in accordance with best practices.

Commitment to Whole Health: Whole Health Director

Our new Whole Health Director will be a public health expert that will serve as the integrator across our functional domains to make sure that we take a culturally competent approach as we deploy programs, engage stakeholders, review data and outcomes, make necessary program changes and adjustments, and support the ongoing evaluation and acceleration of our population health goals and objectives. Healthy Blue's new Whole Health Director will establish, inform, monitor, and execute our integrated whole community health strategy focusing on our five population health pillars: maternal child, behavioral health, rural health, vulnerable populations, chronic disease and prevention, by championing integration and articulating the goals and value of our comprehensive whole health model across our team. They will employ and implement core concepts of whole health improvement such as social determinants of health, health services research, epidemiology, and statistics to guide our strategic planning and will be responsible for building, preserving, and prioritizing collaborative, sustainable relationships with Nebraska's public health, social services, local governmental agencies, and community-based organizations. Our Whole Health Director will also assess population social needs screening tools, use

risk modeling and community needs assessments to leverage relevant information to better understand Nebraska's Medicaid population, and translate that data into actionable evidence to inform strategic planning, policy, and partnership.

No. 17

Training Staff on Issues Affecting Members

HEALTH EQUITY

Social determinants of health (SDOH) are key factors in the health and well-being of Nebraska's Medicaid population. We understand the correlation between social risk and upstream structural and environmental factors, and health outcomes from growing evidence and our own experience serving Heritage Health members. Fundamental to our whole person approach, Healthy Blue builds care management plans that address such factors and provides comprehensive training to all its Nebraska-supporting staff regarding universal SDOH drivers and Nebraska-specific drivers. Our staff Training Plan forms the foundation for our whole person care approach. We update our staff Training Plan at least annually, and upon any significant changes to federal, State, or Plan requirements (for example, trending issues, training needs identified by DHHS or our staff). The staff Training Plan begins with new hire training and continues with ongoing education opportunities and resources to reinforce learning via multiple modalities, including in-person sessions, webinars, and online training.

We regularly evaluate our training curriculum, and create new modules as needed, to provide accurate and timely SDOH information to all our staff, while also making training modules available to our subcontractors who serve Nebraskans. Our Health Equity Director, Tiffany White-Welchen, leads our Health Equity Committee, and helps to develop our overall SDOH and Health Equity Training plan. The Health Equity Director attends conferences, such as Nebraska's annual conferences on Health Equity, bringing up-to-date knowledge to Healthy Blue's leadership. The Health Equity Director will also regularly meet with stakeholders, community leaders, and other Heritage Health MCOs to continually assess the SDOH landscape and guide Healthy Blue's development of appropriate training materials. Periodically, members and providers to participate in various Health Equity Committee meetings to share insights and feedback which are used to inform and shape our training curriculum.

CALLED TO CARE

Tiffany White-Welchen, Health Equity Director

A Nebraska native, I've served Medicaid patients for over 20 years, worked as a Medicaid mental health practitioner for more than 15 years, worked in community mental health for 8 years, and been part of a managed care organization for more than 3 years. My career is more than a job - it's a mission to make a difference in the lives of vulnerable people who need help to navigate the health care system.

CALLED TO CARE: Being able to assist in breaking down barriers, removing health inequities and advocating for Medicaid members is very fulfilling. My parents taught me the importance of not just giving back to the community, but being part of the community. I have a very strong passion for underserved and vulnerable populations and want to continue to assist in educating community members about chronic health conditions, maternal health, and behavioral health. Working together, we can achieve long lasting positive change.

NE_HH22_TiffanyWhiteWelchen_MW_01

Additionally, our Tribal Liaison actively participates in the Health Equity Committee, providing insight and guidance on SDOH factors for the Omaha, Winnebago, Ponca, Santee Sioux, and Ponca tribal populations of Nebraska. Our Whole Health Director also collaborates with the Health Equity Director and Tribal Liaison for SDOH curriculum development. The Whole Health Director is our public health expert that serves as the integrator across our functional domains, making sure we take a culturally competent approach as we launch programs. They will employ and implement core concepts of whole health improvement such as SDOH, as part of our integrated whole community health strategy focusing on our five population health pillars: maternal child, behavioral health, rural health, vulnerable populations, chronic disease, and prevention.

Along with our Health Equity Director, Healthy Blue leaders also attend a variety of local and national conferences that address SDOH and continue to provide ongoing and evolving insights and direction for our staff Training Plan. Recent participated conference includes the following:

- APA Annual Meeting
- Behavioral Health Education Center of Nebraska; Promoting the Collaborative Care Model of BH Integration
- Opioids: Health Care's Paradox Education and Resources for the Workforce (Omaha)
- Regional Health Council Listening Session: Mental Health
- AMCP Great Plains Continuing Education Conference
- Bryan Heart Institute Fall Conferences
- COPIC Annual Symposium
- Lincoln Chamber of Commerce
- State Chamber of Commerce Annual Business Meeting
- MER Primary Care Conference
- Nebraska Association of Transportation Providers
- Medications for Addiction Treatment in Adolescents
- Wakanyeja: A Symposium on American Indian Behavioral Health
- Cultural Considerations when Working within Indian Country
- White Supremacy Resurgences and Cultural Healing for Asian, Native, and Black Youth
- Nebraska Association of Behavioral Health Organization Annual Conference
- Nebraska Juvenile Justice Conference
- National American Indian/Alaskan Native Behavioral Health Conference

Healthy Blue Social Determinants of Health Training

Table V.D.17-1 highlights the comprehensive training curriculum we provide to Healthy Blue staff through the Learning Management System, our staff training platform, educating on the SDOH drivers that impact Nebraskans and their access to health care. All modules are reviewed and updated annually, at minimum.

Table V.D.17-1. Healthy Blue SDOH Training Modules.

SDOH Driver	Training Module(s) Series
Housing	Drivers of Health: Housing
Education	Housing Employment and Education
Food Security	Drivers of Health: Food Security
Physical Abuse, Sexual Abuse, and Violence	Drivers of Health: Interpersonal Violence, Reporting Suspected Abuse, Neglect, and/or Domestic Violence of Children and Adults
Behavioral Health	BH Treating the Whole Person
Long-Term Services and Supports (LTSS) and Members with Intellectual and Developmental Disabilities (I/DD)	LTSS
Transportation	Drivers of Health: Transportation

Live SDOH Training. As a supplement to online training, we will provide live training to our staff. During this interactive SDOH training, a Trainer walks learners through the definition of SDOH, how various social factors can influence health and social outcomes, Maslow's Hierarchy of Needs, the Adverse Childhood Experiences study, and how coordinators can take all of these factors into account when partnering with members to effectively connect them to resilience building resources. Our staff have the opportunity to work within the Community Resource Link platform to identify appropriate resources for a case study. The objective of this training is for Healthy Blue staff to walk away with a better understanding of the following concepts: how to see a person in the context of their family, community and society, how federal/state/local programs/policies impact communities, upstream vs downstream thinking, meeting a person where they are and recognizing when downstream symptoms are better supported with an upstream resource, and the important role coordinators play in building resilience.

Locating Community Resources and Making Referrals (SOW V.D.6.d)

Care Management and Case Management staff undergo thorough Community Resource Link training regarding our community-based partners and the services they can provide our members. We educate our CM staff on the availability of community resources, the importance of tracking this information, and conducting warm handoffs between our CM staff and community-based organizations (CBO), whenever possible. Our community partners also actively assist with training our staff throughout the year, with information on best practices regarding referrals, handoffs, and resources that each provide. Community Resource Link 101 training sessions are held the first Wednesday of each month and the Community Resource Link 201 training sessions are held the third Wednesday of each month.

Thorough Training of All Healthy Blue Staff (SOW V.D.6.b,f)

We hire staff, and engage subcontractors, with appropriate education and experience in serving Medicaid members. As part of our onboarding process, every staff member participates in required Nebraska-specific trainings. Such trainings include an overview of the State of Nebraska and a cultural competency module focused on Nebraska's culture and populations. We develop and update these modules through proactive analysis of our ongoing experience in the state and through collaboration with key CBOs. Table V.D.17-2 describes the contents of these training experiences.

Table V.D.17-2. Nebraska Training Modules (SOW V.D.6.b,f).

Training Module	Contents
Nebraska Market Overview	▪ Information about key cities ▪ Information on the geography, demographics, and economy of Nebraska ▪ Healthy Blue Medicaid plan goals ▪ Eligibility and enrollment ▪ Overview of member's benefits ▪ Nebraska's Presumptive Eligibility Program ▪ Overview of MLTC and its policies, the Medicaid Managed Care contract, and state and federal requirements specific to individual staff job functions ○ Policies and procedures on advance directives in accordance with 42 CFR §422.128 ○ Needs of the LTSS population, including individuals with developmental disabilities and mental health concerns ○ Staff members who have contact with members or providers receive initial and ongoing training regarding program changes, prior authorization modifications, and the appropriate identification and handling of quality-of-care and service concerns
Nebraska Cultural Sensitivity	▪ Population by Race and Ethnicity ▪ Languages Spoken ▪ County Demographics ▪ State Demographics ▪ County Map ▪ Nebraska's Cities and Large Towns ▪ American Indian Protections ▪ Nebraska Reservations ▪ Tribal Resources ▪ SDOH ▪ Nebraska's Refugee Population ▪ Mortality Statistics

Training Module	Contents
	▪ Occupation and Income ▪ Education Statistics ▪ Unemployment and Disability ▪ Housing Statistics ▪ Health Care Statistics ▪ High Risk Behavior ▪ Physical and Sexual Abuse ▪ Top Nebraska Surnames

We require additional training modules to be completed by all Healthy Blue staff, Healthy Blue tracks the completion of these modules through our Learning Management System, which is inclusive of annual performance reviews and goal setting processes, holding both individual staff members and their manager accountable. Additional training modules include the following (SOW V.D.6.a,b,c,f):

- Culture of Poverty Training
- Cultural Competence in Health Care
- Drivers of Health: Introduction
- SDOH Referral Training
- Introduction to Health Equity
- Keeping Promises Training: American Indian Foundational Training
- Medicaid Cultural Competency
- Overcoming Unconscious Bias in the Workplace
- Overcoming Your Own Unconscious Biases
- Reporting Suspected Abuse, Neglect, and/or Domestic Violence of Children and Adults
- Neurodiversity Training
- Sensitive Services-Substance Use Disorder Guide
- Your Role in Workplace Diversity

Additional Training Opportunities

Town Halls. We schedule regular town hall meetings with staff, led by Healthy Blue's CEO, as a periodic update and conversation about local needs and experiences in Nebraska. These meetings occur in the second month of each quarter. While each town hall focuses on a different Nebraska topic, they are open to questions by staff regarding SDOH topics. The Health Equity Director attends the town hall meetings and provides updates regarding Nebraska's SDOH landscape. The town halls are also available virtually, for those who cannot attend in person, and we record each session for viewing by those who cannot attend the live meeting, as well as for future viewing by any interested staff.

Lunch and Learns. Lunch and Learn sessions are held at least monthly. Our CBO partners also provide regular training to our Nebraska staff through Lunch and Learn sessions. Similar to the town halls, we conduct these sessions both on-site and virtually, and record for future viewing.

National Forums. Our parent company has established both Foster Care and LTSS Forums attended by our affiliate health plans. These monthly forums share best practices and innovations that can be considered and implemented to serve our Nebraska members.

MLTC Meetings and Training Attendance (SOW V.D.6.g,h)

Healthy Blue will continue to provide appropriate staff representation in meetings or events scheduled by MLTC. We likewise will continue to welcome MLTC staff to attend all training and seminars we provide for our staff. We will continue to supply MLTC with a list of training dates, times, and locations a minimum of 14 days prior to their occurrences.

No. 18

Medical necessity documentation, or lack thereof, is one of the most common reasons for claims denials. Healthy Blue collaborates with our providers and the state, using data trends and other feedback mechanisms, to make sure that our definition and criteria meet compliance standards while still delivering the highest-quality care to our members.

Healthy Blue's Definition of Medical Necessity

We apply the following MLTC-approved definition of ***medical necessity*** to our utilization management (UM) and care management policies.

Medically necessary services are those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. To be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life; cause suffering or pain; or have resulted or will result in a handicap, physical deformity, or malfunction
- No more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease

Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and neither more nor less than what the recipient requires at that specific time. Services that are experimental, not approved by the FDA, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary.

Our CEO, Dr. Robert Rhodes, in consultation with our Chief Medical Officer, may consider authorizing services at their discretion on a case-by-case basis. We cover only those items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

Process for Developing and Revising the Definition of Medical Necessity

Our process includes actively engaging network providers in developing, adopting, and reviewing our clinical practice guidelines and adherence to Mental Health Parity and Addiction Equality Act requirements. Although our clinical criteria are objective and provide a rules-based system for determining medical necessity (prospectively, concurrently, and retrospectively), our UM clinicians understand that unique, patient-centered circumstances always factor into our decisions. ***We evaluate application of our criteria based on individual member needs and preferences, an assessment of the availability of services within the local delivery system, and the treating provider's request.*** We also consider community-based supports and services to make sure that we do not duplicate services.

Healthy Blue regularly reviews the definition of medical necessity, developing, revising, and updating UM criteria annually and when MLTC requirements or utilization trends require review or revisions. Maximizing the delivery of appropriate services and minimizing occurrences of over- and underutilization are primary functions of our UM program. We adjust clinical practice guidelines on review of clinical indications for new medical services or procedures and new uses of existing services or procedures. Through a formally scheduled process, Healthy Blue reviews and develops medical policy and UM guidelines, as necessary. In addition to our annual review, we monitor over- and underutilization reports and prior authorization (PA) approval rates to identify opportunities to update our list of services that require PA. Quarterly, we review PA requirements, trends in approvals and denials of services, and trends in utilization not currently reflected in our services that require PA and incorporate them into our Quality Management (QM) program.

We use a variety of mechanisms to identify services we believe no longer require inclusion on the standard authorization list for medical necessity determination, including:

- **Provider Collaboration and Feedback.** We obtain regular provider feedback through our MAC, peer-to-peer discussions between providers and our Medical Directors, as well as quarterly and annually through our provider satisfaction surveys. For delegated UM, we monitor provider and member grievances, appeals, and UM trends through regular delegation oversight meetings. The collected feedback is analyzed and incorporated into performance improvement measures across Healthy Blue
- **Feedback from MLTC and DHHS.** We welcome feedback from MLTC and DHHS and implement changes to our definition of medical necessity as directed
- **Data Mining.** We review PA requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our list of services that require PA

Methodical Analysis of Medical Necessity Guidelines

We have access to additional resources and best practices from across the country through our affiliate health plans, including committees that make sure that our UM program aligns with nationally recognized best practices. Our Nebraska Medical Directors are closely involved in the activities of these committees, either through direct membership or reporting through other committees or at the regional or health plan level. These committees make sure that local recommendations are considered and any concerns for policy regarding proposed policy changes are addressed. Our Nebraska Medical Directors participate in all these committees to make sure that local recommendations and concerns for policy change are addressed. The collaboration of these committees helps us design, inform, and evaluate our overall UM program. The UM Committee is aligned with and accountable to these committee structures:

- **Clinical Advisory Committee (CAC).** Our CAC engages local physical health and behavioral health (BH) providers as well as providers representing the types of services our members receive. It reviews and provides input on QM activities, claims trends, and other significant developments and approves clinical practice guidelines to confirm the local Nebraska practice context; approves UM criteria, program evaluations, and descriptions; and reviews information about appeals, grievances, pharmacy updates and recalls, credentialing updates, and peer review for quality of care issues. The CAC conducts peer reviews to assess provider quality of care issues and discusses plans of action. The committee also monitors practice patterns and drug utilization to verify appropriateness of care as well as improvement and risk prevention activities, including review of clinical studies, development and approval of action plans, and recommendations for quality improvement (QI) studies. Members include our Chief

Medical Officer; BH Clinical Director; QM leaders; and seven network providers, including three psychiatrists, one internal medicine physician, one OB-GYN, one family nurse practitioner, and three family medicine physicians

- **UM Committee (UMC).** Chaired by our Chief Medical Officer and our Case Management Administrator, our UMC oversees all UM and social determinants of health (SDOH) program activities and processes, including delegated clinical services. The committee reviews, monitors, and evaluates UM program compliance with Healthy Blue standards, state and federal laws and regulations, contractual requirements, and NCQA standards. The UMC reviews the annual UM and Population Health Management program descriptions and work plans; assesses the program's overall effectiveness, including long-term inpatient stays; monitors grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities for recommendations; and focuses on both physical health and BH continuity of care
- **Health Equity Committee.** Chaired by our Health Equity Director and with participants representing members, advocates, providers, and representatives of community organizations, the Health Equity Committee informs and guides our efforts to create a more equitable health care experience. The committee will also focus on rural area disparities to improve quality of care, reduce health disparities for members in underserved areas, and meet members' SDOH needs
- **Member Advisory Committee.** This committee promotes a collaborative effort to enhance the MCO's patient-centered service delivery system. It provides input and advice regarding the MCO's program and policies. For in-person meetings, Healthy Blue offers a gas card to attendees in addition to serving them lunch
- **Dental Quality Assessment and Performance Improvement (QAPI) Committee.** Chaired by our Dental Director, this committee promotes a collaborative effort from health plan leadership, members, and providers to direct and review QI activities. It implements Dental QAPI activities, tracks and analyzes data, defines goals and key performance indicators, and provides strategic direction and oversight

Additional advisory committees and workgroups include:

- **HEDIS® Taskforce.** This taskforce is responsible for strategy development, deployment, and monitoring to achieve outcome goals. The roles and responsibilities of the taskforce include review of critical measures and current status to drive improvement; strategic planning on how to improve and develop initiatives; assignment of tasks, business owners, and timelines; development of solutions to gaps and identification of root causes; and ongoing monitoring of intervention progress and nearness to goals
- **Performance Improvement Plan (PIP) Workgroup.** The PIP workgroup is responsible for oversight and monitoring of all Healthy Blue PIP projects, including tracking performance indicators and development and monitoring of interventions. This workgroup uses key QI framework principles, such as the Plan-Do-Study-Act methodology and root cause analysis

If it is determined that the medical necessity criteria are not available or not specifically addressed for a service or a particular population, we submit the proposed criteria to MLTC for approval. We disseminate changes in authorization requirements in alignment with contractual requirements by delivering provider notifications, posting changes on the provider website and member portal, and updating member and provider handbooks. Our Provider Experience team also less formally updates providers during their ongoing touchpoints in person or over the phone.

Comparison Between Our Medical Necessity Definition and MLTC's

Healthy Blue uses a definition of medical necessity that is aligned with MLTC's definition. We submit our definition to MLTC annually for review and approval before applying the definition to the care of members.

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No. 20

EPSDT, or Health Check in Nebraska, helps assure that children and adolescents receive appropriate preventive physical health (PH), behavioral health (BH), dental, developmental, and specialty services. To influence member behavior through our EPSDT education and outreach, we align our goals with the Nebraska Quality Strategy for Heritage Health. Our Healthy Blue EPSDT engagement strategy leverages the Quadruple Aim, which focuses on improved member and provider experiences and outcomes, enhances the health of populations, and reduces the per-capita cost of health care. We assure appropriate care management and coordination of BH services using our fully integrated EPSDT strategy, which is overseen by our Maternal Child Health (MCH)/EPSDT Coordinator and our EPSDT Specialist. Our EPSDT Specialist facilitates and coordinates timely access to care for EPSDT members. Our EPSDT program includes strategies to monitor and improve EPSDT through member engagement and incentives, provider engagement, innovative interventions and mechanisms, and ongoing monitoring and tracking. Our EPSDT program policies and procedures comply with all statutes, regulations, administrative rules, and contract requirements governing child health screenings in the federal periodicity schedule and established timeframes in SOW E. Covered Services and Benefits, Section 13 EPSDT Benefits. Through our education and outreach, we improved multiple metrics, including early lead screening and preventive care metrics, as demonstrated in Figure V.E.20-1.

EPSDT Member Education and Outreach

Our quality management and care management cross-functional and interdepartmental approach connects children and their caregiver and/or guardian with EPSDT services and identify chronic or complex clinical issues so children have the best opportunity to grow into healthy, productive adults. Every family receives education about EPSDT and rights to coverage for children's services. To reinforce the information in our onboarding materials, such as our new member welcome packet, new member welcome calls, and member handbook, we supplement our communications through:

- **Enrollment Process with Healthy Blue.** Within 60 days of enrollment, using clear, plain language, we provide each member access to information and services available under the EPSDT program, and where and how to obtain those services. The member handbook includes information regarding EPSDT and how members are eligible to participate.
- **Member Engagement.** Initiatives resulting in member contact, education, and awareness of EPSDT services are communicated through traditional, digital, and social media methods.
- **Education.** In addition to written materials and outreach campaigns, we also provide education through community-based organizations and community events. Since 2017, we have partnered with Bright Futures in Kearney to engage members in education and outreach events such as to offer vaccinations, dental, or other preventive care services.
- **Service Resolution and Retention.** Member engagement is enhanced through our ongoing care management outreach, reinforcement of education, and engagement programs.

REAL STORIES

A **6-year-old EPSDT member in foster care** who has a history of respiratory failure with a tracheostomy and vocal cord paresis was recommended for a ventilator at night. We worked collaboratively within our UM team to swiftly approve a typically non-covered home ventilator for this member.

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Every Care Manager (CM) receives training to assess and identify gaps in care. Through our case management system, Health Intech, gaps in care are clearly indicated in members' personal health records. All care management assessments include elements to assess EPSDT. Any barriers are discussed and addressed in the member's care plan, which includes assistance with appointment scheduling and coordination with the member's providers. Our Quality Management/Quality Improvement team proactively sends EPSDT reminders to members via calls, texts, and letters. Using data and claims analysis, we notify members when they are overdue for services. Our approach to encouraging members to obtain needed services begins with education and includes an array of outreach and engagement strategies, such as personalized support from our local Community Health Workers (CHWs) who share the member's cultural and ethnic background when possible. We support members with outreach activities such as:

- **Welcome Rooms.** Our five Welcome Rooms in Nebraska (in Scottsbluff, Norfolk, Kearney, Omaha, and Lincoln) host baby showers, provide information on importance of EPSDT visits and immunizations, and have telehealth kiosks (with translation capabilities available) that include a tablet to take to a private area.
- **Member Website and Sydney.** Members have 24/7/365 access to user-friendly materials and resources on our website and Sydney, our secure member portal and digital app. They can register online for our Healthy Rewards to begin receiving incentives for completing EPSDT services. Our online content educates members about when and how often to schedule visits for EPSDT exams, screenings, tests, and vaccines. The portal includes Bright Futures Guidelines for preventive health including the periodicity schedule by age group, which includes infants, early childhood, middle childhood, and adolescence.
- **Text Messages, Live Calls, and Annual Birthday Card Mailings.** We provide streamlined texting capabilities to offer preventive health outreach reminding members to receive preventive care. We call members with a gap in care and provide appointment scheduling assistance and education about our Healthy Rewards. Our annual birthday postcard mailings remind members of any

screenings or visits needed. [redacted]

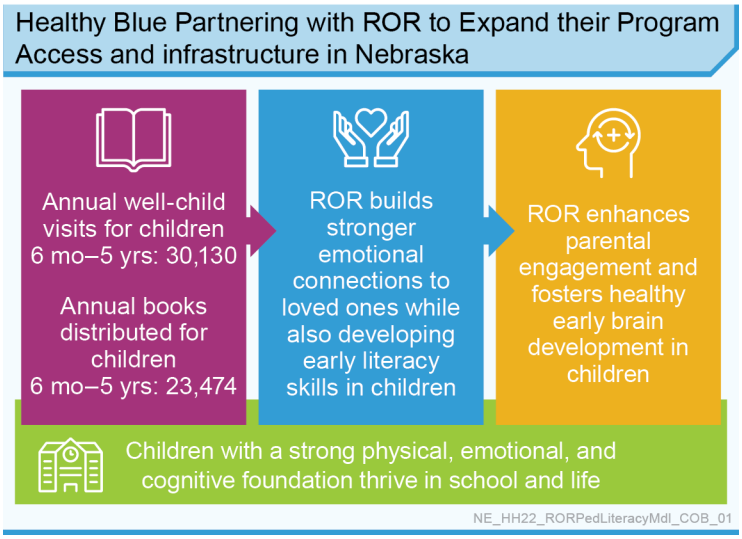
- **Healthy Blue's Pregnancy and Beyond.** Materials provide coverage and health information about pregnancy and the postpartum period, including immunization schedules and screenings to keep new babies healthy.
- **Pregnancy Support App.** Members receive telephonic or digital communications twice a week with information relevant to their perinatal stage through 12 weeks after delivery to provide education about pregnancy, newborn, and infant wellness.

We develop processes and procedures and designate points of contact for collaboration with other entities that service members and work with DHHS and families to assure children access these screenings and services. Figure V.E.20-2 outlines our process to encourage members and their families to obtain EPSDT services.

[redacted]

Educating Pregnant Women and OB Providers to Promote Healthy Babies and Children. A key component of our strategy targets education for pregnant women to develop a plan for their babies to receive EPSDT services. We align our ***Advancing Maternal and Child Health*** program with EPSDT service outreach and education to support improvements in child health outcomes associated with pregnancy. We inform new moms of available services at their local health departments and through other community or faith-based partners such as Heartland Home Mission. Our provider website has a page devoted to EPSDT, which includes a provider toolkit. Our EPSDT/MCH Coordinator serves as a resource to work with perinatal providers:

- Provide education about newborn care and a well-child visit within the first few days of the baby's birth
- Encourage pregnant members to identify a provider for her newborn and complete a pre-birth selection form
- Refer members to us for health education on well-child visits, newborn care, and parenting
- Incorporate EPSDT screenings and immunizations with prenatal and postpartum care visits



[redacted] We make EPSDT a priority to address the State's program goals, including the promotion of primary and preventive care as shown in Table V.E.20-1.

Table V.E.20-1. Innovations to Promote Members' Screenings, Immunizations, and Access to EPSDT Services.

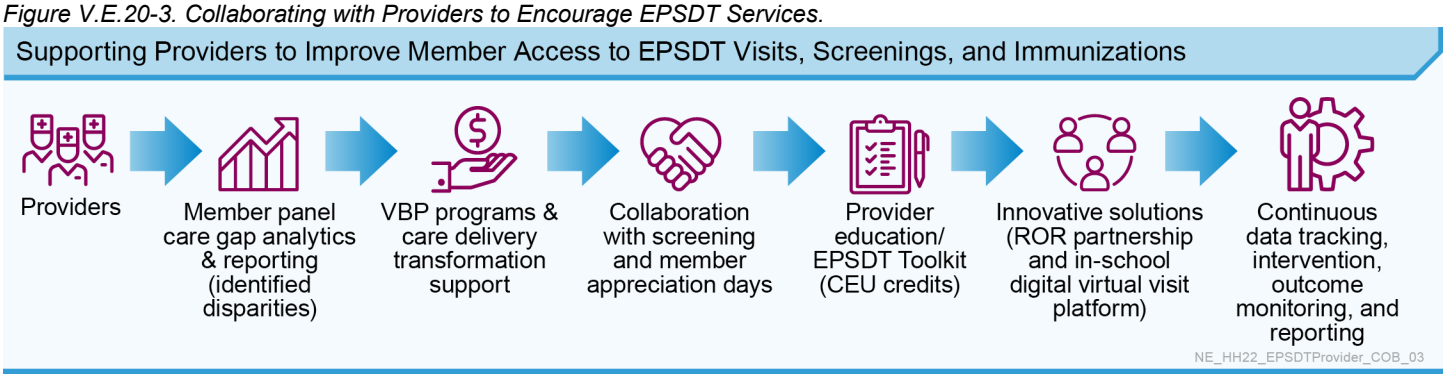
Outreach	Description
Child/Family Education and Health Literacy	Our new member welcome call and member enrollment packet (which includes the member handbook) will inform members about covered services, including well-baby/well-child visits, immunizations, developmental screenings, transportation, our provider directory, how to schedule appointments, our value-added services (VAS), and Healthy Rewards. All information is culturally and linguistically appropriate, below or at a 6.9 grade level, and easily accessible through the member portal and Sydney.
Child/Family Engagement	We connect members to wellness education, screenings, and immunizations available through school-based clinics, at our proposed physical location for member outreach (Welcome Rooms) through back-to-school events and immunization clinics, and through community-based organizations, such as local churches and community health centers. Events include vision screenings provided by our vision partner.

Outreach	Description
Connection to Transportation and SDOH Resources	Our Care Management teams assist families with transportation arrangements and coordinates access to resources to address the member's unmet social determinants of health (SDOH) needs identified through the initial Health Risk Screening (HRS) and SDOH assessment. We use Community Resource Link, our community-based referral platform, to link members with community resources. Data from this platform integrates into our Health Intech platform to track and make sure members access the resources.
[redacted]	[redacted]
Member Panel Care Gap Analytics and Reporting	Our web-based reporting platform offers providers member-specific data including care gaps and high-risk conditions. We generate monthly provider-specific gaps in care reports of members missing elements of recommended care (such as preventive health services), targets for HEDIS-measured procedures and visits, and member contact information. ***We segment provider reports, including provider scorecards, by demographics to show disparities among their panel members.***
Value-based Purchasing (VBP) Programs	We engage providers and encourage them to participate in our VBP programs that reward specified improvements in child and adolescent screenings and immunizations, and for detecting and addressing early childhood trauma and BH needs. [redacted]
Collaboration with Screenings and Member Appreciation Days	During member appreciation days, we help providers schedule members within a designated appointment window who are due (or overdue) for screenings and immunizations. We make reminder calls to increase gap closure and offer some events curbside to reduce visit time and for ongoing safety during the pandemic. In an affiliate state, community-based organizations bring diapers and boxes of nutritious food and healthy recipe cards to the provider's office, an approach we will use in Nebraska.
[redacted]	[redacted]

Supporting Providers to Improve Member Access to EPSDT Services

Healthy Blue assists PCPs in notifying members to comply with all EPSDT periodicity schedule requirements. We increase access to timely care through innovations and partnerships such as telehealth services, e-consults between PCPs/PCMHs and specialists, and provision of in-home services to close care gaps and meet needs, as shown in Figure V.E.20-3.

Figure V.E.20-3. Collaborating with Providers to Encourage EPSDT Services.



We will contract with all qualified EPSDT providers and use the State's monthly list of qualified EPSDT providers to identify and recruit newly identified EPSDT providers for our network. Our dental and vision partners will conduct periodic dental and vision examinations for children and adolescents and provide timely access to needed services through our local providers. They provide a monthly report of systemic and chronic medical conditions found during a child's vision exam, which we will share with the child's PCP or PCMH and our Care Management team for coordination of care. In additional to our EPSDT outreach, we complete targeted dental outreach, and we work with our dental vendor, Liberty Dental, to identify members who are overdue for their dental visits.

[redacted]

Healthy Blue monitors HEDIS rates every month to partner with providers on their performance and to support targeted member outreach. We meet regularly with providers to review performance and progress on HEDIS scores. We encourage providers, through financial incentives, to help us meet our quality improvement goals for HEDIS well-child measures as show in Figure V.E.20-4.

Tracking Services to Assure Timely Delivery

We identify members in need of or underutilizing EPSDT services and reach out to their parents (for younger members) or to young adult members under the age of 21, to make sure they have the information and support needed to access these services. We assure completion of initial visits for newborns, EPSDT screenings and reporting of screening results, and diagnosis, treatment, and referral. Our tracking system supports collecting EPSDT compliance information and requirements through ongoing review of medical records, claims and encounter data which we evaluate through continuous data tracking, outcomes analysis, intervention, and outcome monitoring and reporting. Our local Quality Management Coordinator oversees our data-driven quality improvement approach that will leverage the continued quality improvement process to evaluate our member- and provider-focused EPSDT activities. We will evaluate our quality data, membership, service utilization patterns, and year-over-year performance measures to identify, implement, or adjust interventions.

We generate a monthly report of members who are due for an EPSDT service or who have not been seen by their PCP in 12 months from a review of monthly claims and encounter data. We then send age-specific preventive health reminders 45 days prior to the child's birthday and 90 days after preventive care is overdue via push notifications through Sydney, in postcards, and through text messages. If EPSDT gaps persist, we implement interactive text messages, live calls, and mailings to parents or young adult members, supplemented by home visits from our Care Management team and CHWs.

We conduct biweekly reviews to identify continued gaps in children's preventive services, including past due well-child visits, immunizations, and developmental screenings. Health Promotion staff make live calls to parents or young adult members not engaged in a care management program to inform them of preventive services due. They provide education about how to access their PCP for scheduling, offer information about the Healthy Rewards member incentive program, and help arrange transportation. They aggregate and report data collected on members' barriers to care that we then evaluate when adjusting our outreach and engagement activities. For example, we redesigned our EPSDT member materials to improve readability and translated them into Spanish in response to identified barriers. Our Care Management team makes reminder phone calls to families or young adult members engaged in care management and provides in-person assistance as needed to help review needed preventive care and services and arrange appointments and transportation. We assign a pediatric nurse to each county who serves as a direct point of contact to facilitate EPSDT services and coordination of care.

Quality Improvement, EPSDT Data, and Utilization Outcomes. We continuously manage, monitor, and measure EPSDT and HEDIS performance, including EPSDT service trends and rates at various population levels, to identify possible barriers to completion. We analyze all available EPSDT-related data to identify underutilization and to provide actionable insights, including "hot spotting" for rising areas of risk and potential health disparities. We review feedback from our Member Advisory Committee, Clinical Advisory Committee, and from community stakeholders to better understand barriers to receipt of preventive care and services. We then implement targeted member outreach through CHWs and live calls in areas where we identify low rates of well-child visits and immunizations and help schedule the appointment and arrange transportation. Our monthly HEDIS Taskforce meetings focus on EPSDT and include data analysis, trend identification, and development of member, provider, and community interventions. Identification of disparities, including in EPSDT services, is a key focus of our population health strategy and quality initiatives. We monitor disparities among our membership as part of our annual Culturally and Linguistically Appropriate Services and health disparities program evaluation, which we review quarterly, and from review formally throughout our Quality Committee structure. If we identify a pattern of underutilization associated with a specific subpopulation or providers, our Quality Management team, working with our Care Management, Utilization Management, and Provider Experience teams, evaluates underlying causes and potential solutions. We can implement a focused phone campaign for all children within a specific area, design and test a new initiative to boost member and family engagement, and work with high-volume, under-performing providers to implement member appreciation days.

No. 21

Using Telehealth and Telemonitoring Services

COVID-19 underscored the importance of providing members with the option to connect virtually with their providers. Healthy Blue allows all provider types to conduct telehealth visits in accordance with MLTC requirements. We cover medically necessary services via telehealth at the rate of an in-person visit, including those PCPs that are receiving the Enhanced Primary Care rates. We also reimburse the originating site if the visit occurs in a clinic setting. Additionally, we offer telehealth and exam kits to maximize the effectiveness of these visits. We also conduct outreach to identify which providers are offering virtual services and include an indicator in our provider directory so members can easily identify these providers.

A significant component of our telehealth strategy is providing our Nebraska providers with the tools they need to offer telehealth to their existing patients. We require providers who deliver care through telehealth to follow all applicable federal and state regulations governing their practice and the services they provide. Additionally, our proposed national telehealth vendors prioritize incorporating local Nebraska providers within their networks. Our proposed approach is described in full in Table V.E. 21-1.

We will continue to expand robust telehealth offerings to supplement traditional service methods and expand access to culturally competent care providers, thereby expanding options to accommodate member preferences.

Identifying Member Preferences

As telehealth has become more sophisticated and widely used, access to care has greatly expanded, especially for those members with special or emergent needs or who live in rural or underserved areas. We provide comprehensive education to members on the availability of telehealth options and how using these services can improve their health and decrease health care costs, to aid in their decision between using an in-person or telehealth provider visit. Information is included in the member handbook, the provider directory, in member communications, on our member portal, on our mobile app, via texts, at community events, and in meetings with Care Managers (CMs). Members can access telehealth services through our mobile member portal, accessible from either a computer or mobile app, and can ask questions about how to access telehealth services by calling our member services line. New Healthy Blue members also receive a welcome call from a Member Services Representative who will educate them about LiveHealth Online.

For members engaged with care management, the CM team will provide education about telehealth through ongoing CM contacts. With the CM team's support, the member can make an informed decision regarding which telehealth options can be included in their treatment plans and treatment plans that are created in conjunction and collaboration with the member's PCP/PCMH. CMs will assist members in identifying opportunities to use telehealth as part of their discharge plan, which is often more convenient for members and may decrease readmissions. CMs will also help identify community-based organizations (CBOs) used by members to share telehealth information and provide support to individuals, such as older adults, who may not be as familiar with technology. The CM team reaches out and collaborates with members to determine the best approach to care and what modality members prefer. Whenever possible, members will be given a choice between in-person or telehealth services.

Healthy Blue will also leverage feedback from our Member Advisory Committee (MAC) to identify member preferences. In 2022, we began surveying our MAC to ascertain preferences between telehealth and in-person options. We will continue to do so on an ongoing basis and develop and expand our telehealth solutions in response to that member feedback.

State-wide Operations

Healthy Blue is committed to implementing ***innovative telehealth solutions*** that expand provider capacity and member access to primary and specialty care, in compliance with MLTC rules and regulations. When we identify an access shortage for a particular provider type, we prioritize outreach to those providers in our network to establish whether they are willing to expand access to their services through telehealth. We also provide PCPs with access to virtual consultations (e-consults) with specialty providers to help fill gaps for key provider shortages in rural or frontier parts of the state, such as cardiologists, orthopedists, and mental health and SUD providers. The e-consults provide access to Medicaid-enrolled specialty providers who are in the Healthy Blue network but where distance would otherwise be a barrier to access.

Healthy Blue will provide a comprehensive overview of our telehealth offerings and resources available to our providers during both initial orientation training and ongoing training. We will also train providers on Nebraska requirements related to the provision of

telehealth services, including proper billing procedures. Our provider portal will also offer telehealth resources, links, training modules, and timely notifications of updates to Nebraska telehealth policy.

Our Provider Experience team will include a **Telehealth Program Manager**, who will work with providers to assure that they have the information and resources needed to successfully implement or expand telehealth services in their practices, including assistance with technical and billing issues. [redacted]

Figure V.E.21-1. Healthy Blue is Committed to Increasing Opportunities for Members to Leverage Telehealth.

Expanding Broadband Access in Rural Areas

"This donation will provide our rural communities with resources to stay connected, promote health and wellness, and enable emotional and social support," said Dr. Rob Rhodes, Healthy Blue Nebraska President. "If rural patients have a good internet connection, they can expand their options for medical services and specialists while also saving time and money. Healthy Blue continues to adopt a digital-first approach within the local community and connect with members when they want and how they want it, putting them at the center. Technology is helping close gaps in care and better support members across the state. Connectivity is crucial for continuing education, getting or maintaining a job, and accessing benefits and services."

NE_HH22_ExpandingBroadbandAccess_Q21_COB_01

Many Nebraskans lack connectivity and have little to no broadband access. High-speed internet connectivity is an SDOH challenge, and those without it cannot participate in the digital transformation of health care. Healthy Blue will continue to promote telehealth and help overcome any hesitancy or other barriers to adoption, including limited broadband access, as demonstrated in Figure V.E.21-1. To further assist with increasing access to broadband service, Healthy Blue provided $100,000 to the University of Nebraska at Kearney's Rural Measures project to help expand broadband access in Nebraska. [redacted]

In partnership with DHHS, we will implement the National Diabetes Prevention Program (DPP) through telehealth sessions with members. The program addresses known disparities in access, especially rural and disease prevalence, by providing a virtual platform along with equipment such as a tracker and scale, and necessary equipment for virtual care such as tablets and cell access, if needed. Delivery through a health care system should also increase reach and accessibility.

Incorporating Telehealth into Utilization Management Strategies

The main goal of our telehealth program ***is supplying local providers with the tools they need to effectively manage the care of their existing patients***. Telehealth kits are just one of the tools that make it easier for both the provider and the member to conduct a health assessment, thereby supporting effective utilization management efforts by potentially providing assessment, diagnosis, and treatment before needing a higher level of treatment.

In addition to reducing inappropriate emergency department (ED) utilization, telehealth also helps address barriers to care, such as long transportation distances, which is especially important in states like Nebraska where there is a predominance of rural and frontier counties. It also increases the likelihood that members with co-occurring BH and SUD conditions will seek treatment. We conduct regular monitoring of network adequacy and service utilization patterns to identify gaps and opportunities to improve access to care through telehealth. For instance, we use predictive modeling algorithms to identify super-utilizers and those with high risk of an ED visit, hospitalization, and/or readmission and provide proactive education and support around accessing telehealth options. [redacted] We also track Non-Emergency Transportation (NET) utilization data, including ride trip codes, frequency of trips, and high-mileage trips, for our members that reside in more rural or frontier counties to identify those that may benefit from telehealth services and connect them to such services This analysis allows us to develop targeted solutions to expand provider capacity and members' access to timely and quality care.

We promote the adoption of telehealth through our value-based purchasing (VBP) programs. [redacted]

No. 22

Healthy Blue Has Extensive Integrated Pharmacy Benefit Oversight Experience

Healthy Blue has been overseeing pharmacy benefits in Nebraska since January 1, 2017, when the pharmacy benefit was carved into managed care. Since January 1, 2021, our pharmacy program has been backed by the resources and expertise of our affiliate PBM, IngenioRx, Inc. (IngenioRx). This affiliation facilitates our ability to integrate medical and pharmacy benefits more effectively within the same organization.

In May 2019, our parent company introduced IngenioRx, an indirectly wholly owned-and-operated subsidiary. Collectively, IngenioRx's senior leadership team has more than 100 years' experience within the PBM industry. Leaders from our parent company and IngenioRx have been providing pharmacy services for more than 33 years for commercial pharmacy benefits and more than 28 years providing services for our affiliate Medicaid and Medicare members. When Healthy Blue transitioned to IngenioRx on January 1, 2021, with prior approval from DHHS, we smoothly and seamlessly transitioned more than 100,000 members and experienced no significant issues.

IngenioRx also currently manages the integrated pharmacy benefit in 15 affiliate Medicaid markets for more than 6.6 million Medicaid members (as seen in Table V.E.22-1), including managing clinical programs to improve member adherence, reduce polypharmacy, close gaps in care, and support improvement in HEDIS® measures. Our PBM has extensive experience managing Medicaid pharmacy programs including managing six state preferred drug list (PDL) markets. Each state PDL structure is different, ranging from wholly state-managed, including pricing and formulary management to hybrid markets like Nebraska, where formulary management is split between the state and IngenioRx. In addition, IngenioRx manages the pharmacy benefits of almost 8.5 million commercial members in 14 states and more than 1.5 million Medicare members in 21 states.

Table V.E.22-1. Healthy Blue Affiliate Medicaid Pharmacy Benefits Management.

Medicaid Market	Total Members	Membership Type
Arkansas*	16,880	ABD
Florida*	741,903	TANF, CHIP, ABD
Georgia	589,402	TANF, CHIP
Indiana	730,920	TANF, ABD
Iowa*	449,762	TANF, CHIP, ABD
Louisiana*	361,443	TANF, CHIP, ABD
Maryland	323,795	TANF, CHIP, ABD
Nevada	195,101	TANF, CHIP, ABD
New Jersey	245,423	TANF, CHIP, ABD
New York	560,715	TANF, CHIP, ABD
North Carolina*	449,489	TANF, CHIP, ABD
South Carolina	183,657	TANF, ABD
Texas*	983,615	TANF, CHIP, ABD
Virginia	549,373	TANF, CHIP, ABD
Washington	257,180	TANF, CHIP, ABD

** State PDL*

IngenioRx administers and delivers a full suite of pharmacy benefit management services, including:

- Claim adjudication, including Prospective Drug Utilization Review
- Pharmacy network
- Account management
- 24/7/365 Member Pharmacy Services call center
- Prior authorizations
- Reporting and analytics
- Clinical services, including MTM
- Formulary management and, when required, coordination of State PDL requirements

Our PBM routinely monitors health outcomes of major high-profile drugs or drug classes. For example, they monitor HbA1c for diabetes members. Our PBM also measures reduction in hospitalizations or emergency department (ED) visits and [redacted] These positive member outcomes included at least 80% adherence to diabetic medication, with members receiving appropriate diabetic screening tests and appropriate addition of statin medication.

Our PBM pharmacists are clinicians that are trained to appropriately integrate the State PDL with the Healthy Blue PDL to deliver cost-effective clinically appropriate formulary management. In collaboration with our PBM, we work diligently to manage the drug classes that are not State-managed. Where we are able within select drug classes, the drugs have been chosen to provide the most clinically appropriate and cost-effective medications for patients who have their drug benefit administered through Healthy Blue.

We make sure that members can fully understand their pharmacy benefit and offer programs to assist with appropriate medication use and adherence. We assure all members have easy access to information, tools, and programs that will address their diverse needs. Healthy Blue encourages members to contact us for information about their pharmacy benefit through any of our dedicated Nebraska phone lines or secure online messaging. We also provide multiple resources, such as the member handbook, member website, and Sydney Health (Sydney) mobile application that allow members easy access to coverage information and medical and pharmacy claims

details. Members also have access to our PBM's 24/7 Member Pharmacy Services call center, which is distinct from the traditional Member Services Call Center. Certified Pharmacy Technicians staff this PBM line and can directly answer pharmacy-related questions and provide warm handoffs to other departments to answer additional questions. Members also have access to IngenioRx through a website and Sydney app, to have a complete review of their medications.

Applying Our Experience to Heritage Health Members

We leveraged the experience and lessons learned from other markets to successfully and seamlessly transition the pharmacy benefit to IngenioRx in Nebraska in January 2021.

Our dedicated Pharmacy Director, Shannon Nelson, who has been with Healthy Blue since 2016, works closely with our medical and behavioral health (BH) clinical teams and leadership to make sure that pharmacy services meet all applicable State, federal, and DHHS requirements. Due to Shannon's long-standing tenure in Nebraska (including being on the DUR board for Nebraska Medicaid from 1991 to 2006), she has developed and maintained a working relationship with the State that is built on a foundation of trust. Through this relationship, Healthy Blue and DHHS have regular communication around PDL corrections and clarifications that are needed, and we have fostered a positive relationship based on a common goal of program improvement. She also represents our pharmacy program at the DHHS Pharmacy and Therapeutics (P&T) Committee meetings.

As Pharmacy Director, Shannon also:

- Assures identification and resolution of issues concerning the pharmacy benefit program
- Serves as Pharmacist expert on contractual requirements, beneficiary rights, and standard benefits for the client
- On occasion resolves claims issues and complaints with the support of Pharmacy Operations team or Medicaid Account Management team
- Performs routine benefit surveillance to assure benefits are working correctly
- Assures successful implementation of programs
- Assures all necessary client/vendor accountability reporting is complete, accurately and on time
- Assures strong advocacy for members and providers
- Works within an integrated team approach to resolve member challenges that cross over from physical and BH

Healthy Blue's Integrated Approach to Pharmacy

We have extensive experience working with integrated medical and pharmacy data and we apply this integrated approach and experience to manage the whole patient, improve health outcomes and lower costs. Our fully integrated pharmacy program supports members' total physical and BH needs and includes joint operations, joint clinical meetings and committees, and interdisciplinary teams that facilitate the identification of member needs and implementation of needed care to close gaps. These integrated teams use shared data and reporting, shared goals, and include pharmacy participation on Care Coordination teams. We effectively integrate these benefits with the member's pharmacy benefits by allowing for:

- Focus on total health care costs, including medical, behavioral, and pharmacy costs
- Consistent and aligned strategies and goals to drive development of our member-centric pharmacy and medical programs
- Policy alignment for continuous focus on managing drugs consistently across all benefits, which promotes cost savings rather than cost shifting

Our programs and services integrate pharmacy and medical data to encourage preventive care and medication compliance by removing financial barriers. We also align our medical and pharmacy policies. This means we manage drugs consistently across both pharmacy and medical benefits, which helps assure cost savings rather than cost shifting.

When reviewing drugs and drug classes, we consider the complete disease. This means considering factors such as the progression of the disease, the quality of life, and productivity impacts as well as the total cost of the disease. We design our formulary to help improve quality of care, productivity, and reduce total overall medical and pharmacy costs.

Benefit integration allows us to improve member health outcomes and reduce total health costs in attending to the whole member. For example, pharmacy integration simplifies the prior authorization (PA) process for providers, by matching medical claims with pharmacy adjudication to demonstrate medical necessity for a medication without requiring the provider to submit a separate PA for clinical review. Through proactive coordination of the benefits with actionable data, we can simplify administrative steps for providers and ease member access to medication.

We use timely, integrated data to identify care gaps earlier, and we share this information with members and providers to help them make better, more informed health care decisions. With integration, we continue to coordinate care and leverage actionable data to drive better health outcomes and Nebraskan total health care costs. We also use pharmacy data to help drive HEDIS measures, identify gaps in care, and increase member adherence.

We value integration and understand the total Medicaid member, the Medicaid provider, the Medicaid partnership with the State, and the unique barriers that affect the most vulnerable. Our services include claims adjudication, payment, stakeholder information services and consultation, reporting and data sharing, as well as tailored benefit designs, formulary and rebate management, clinical programs, specialty pharmacy condition management, retail and specialty pharmacy network management, data analytics, and regulatory compliance. We are uniquely experienced to support encounters, value-based purchasing (VBP) arrangements, Restricted Services programs, coordination of benefits (COB), fraud, waste, and abuse (FWA), and compliance and regulatory needs.

We have integrated members' pharmacy claims information into our secured member portal and web application so members can easily view their pharmacy claims summary, view all prescriptions, request refills, check the order status of mail order or specialty drugs, and locate a pharmacy without having to sign into a separate application. Members can also send a secure message to our PBM to get answers to pharmacy-related questions and can request refill reminders via email, call, or text messaging. Members can also search the PDL formulary online through our secure member portal and Healthy Blue's public website.

In addition, IngenioRx pharmacy data integrates seamlessly into our platforms and reporting. Providers see the full picture of Healthy Blue's members in Patient 360°$_{SM}$ (part of our Health Intech platform), including robust pharmacy data and analytics, to promote the

best medical guidance, eliminate care gaps, and reduce cost shifting between benefits. With a holistic view of member health, we have visibility into each member's overall care.

As part of our Restricted Services program, we complete member reviews related to their medication use and send personalized letters to providers when there are concerns. We also conduct morphine milligram equivalents (MME) reviews through our Restrictive Services Interdisciplinary Committee focusing on members with high opioid activity to assure communication exists between multiple prescribers. This integrated clinical team reviews BH, medical, and pharmacy information to identify and address needs of members who may otherwise not receive needed attention.

To further facilitate integrated care, Healthy Blue pharmacy staff participate in meetings with other health plan staff, including team huddles, clinical rounds, integrated care and utilization management meetings, and case consultations as needed, as well as weekly Quad Meetings with the CMO, BH Clinical Director, Pharmacy Director, Quality Management Coordinator, and Case Management Administrator. In this meeting, department leads review departmental goals, discuss barriers and solutions, collaboration sessions on initiatives.

Data-driven Initiatives

Pharmacy data is used in all aspects of our pharmacy program and in other areas, like care management; however, using pharmacy data alone only addresses one aspect of our members' health. While medical and pharmacy claims are adjudicated on separate claims platforms, they are integrated into Member 360°$_{SM}$, part of our Health Intech platform for care management, to make sure we maintain accurate member profiles, which are essential for our Care Coordination team. This integrated data provides a holistic view of the member and becomes an integral part of the member's record. We integrate data with our PBM, such as member diagnosis data so our PBM can auto-adjudicate authorizations at point of sale. It is also readily available to the clinical team and network providers for ongoing reviews of the member's needs, changes in health status, and treatment plans. We can quickly identify changes in medications so action may be taken with the members, their caregivers, and providers to mitigate any risks and increase effectiveness. We promote frequent, open, and effective communication that emphasizes the delivery of quality services to members. Our integrated approach with our PBM uniquely allows us to support whole person care on behalf of our members. Our PBM uses not just pharmacy data in the management of our members' care, but medical data as well. This integrated medical and pharmacy solution provides members and providers with access to actionable data that translates into better clinical management and decision-making.

Predictive Modeling. Healthy Blue deploys data-driven predictive modeling tools, which incorporate pharmacy data, to complete initial screenings and identify members' risk levels. We can assess risk for ED visits, admissions and readmissions, high-risk pregnancies, BH issues, and pharmacy indicators with our Chronic Illness Intensity Index (CI^3), predictive modeling, and other tools. These tools help predict ED, obstetrical, readmission, and pharmacy-related risks and we can use them to identify members with high utilization or at emerging risk to coordinate services and supports. CI^3 uses pharmacy data to help us proactively monitor and mine utilization data to identify members with high rates of utilization who may be at risk for ED visits, inpatient admission, medication adherence issues, or other avoidable problems that might be preventable with proactive member outreach and interventions.

Provider Care Management System. We have created an innovative provider reporting platform, Provider Care Management System (PCMS), for our Nebraska providers who participate in shared savings arrangements which incorporates pharmacy data. PCMS gives providers real-time information to help identify opportunities to improve member health outcomes by specific disease states, such as diabetes and hypertension, and tobacco and substance use. Through a combination of medical and pharmacy claims data, we identify members at high-risk for readmission and members with potential condition-based clinical needs. This helps providers identify members who will benefit most from care planning and increased care coordination.

Healthy Blue's Integrated Pharmacy Management Program Complies with State Requirements

Together with our PBM and leveraging our PBM's integrated pharmacy benefit experience in Nebraska and other Medicaid markets, our integrated pharmacy management program meets all requirements as outlined in SOW V.E, Covered Services and Benefits.

For example, we will continue to:

- Provide coverage for all drugs and therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and follow the Nebraska Medicaid preferred drug list (State PDL)
- Provide coverage for medications to prevent or treat disease for members under 21 years of age
- Submit any proposed pharmacy service or coverage changes to MLTC for review and approval a minimum of 120 calendar days prior to the Contract Start Date and 45 calendar days prior to the proposed implementation date of any change following the Contract Start Date

Our PBM will also continue to follow the Nebraska Medicaid PDL. In 2021, [redacted] of total scripts for drugs on the Nebraska State PDL were for preferred products. We will also leverage the experience of our affiliate Medicaid markets, including those with State PDLs, to continue to determine best practices to improve member access and reduce provider abrasion.

No. 23

Our Parent Company has Extensive Integrated Dental Benefit Experience

Our parent company has extensive experience managing an integrated dental benefit for almost four million members through our affiliate health plans in 12 other markets, as listed in Table V.E.23-1. In addition to our Medicaid experience, our organization also manages the dental benefit for almost one million Medicare members in all 50 states.

Table V.E.23-1. Healthy Blue Affiliate Dental Benefit Management Experience by Market.

Medicaid Market	Total Members	Membership Type
Georgia	573,061	CHIP, TANF
Indiana	734,731	TANF, ABD
Kentucky	172,835	CHIP, TANF, ABD
Maryland	125,673	CHIP, TANF, ABD
Minnesota	347,336	TAN, ABD
Missouri	360,765	TANF, CHIP
New Jersey	245,727	CHIP, TANF, ABD
New York	561,962	CHIP, TANF, ABD
Texas	21,616	CHIP, TANF, ABD
Washington	152,205	CHIP, TANF, ABD
West Virginia	202,246	CHIP, TANF, ABD
Wisconsin	154,373	TANF, ABD

In Nebraska, we are partnering with Liberty Dental to administer the dental benefit for Heritage Health members. As one of the nation's largest dental benefits administrators participating in government programs, Liberty Dental is a NCQA (for UM and credentialing) and URAC-accredited entity with 17 years' experience delivering full-risk, comprehensive dental benefits in standalone and integrated dental programs to Medicaid and CHIP members nationwide. Currently, Liberty Dental manages the dental benefits of more than six million members across all markets, including almost four million members in six Medicaid markets, 580,000 commercial and exchange members, and more than one and a half million Medicare members in all 50 states and Washington, DC. Liberty Dental will provide high-quality dental services to our members by delivering a full suite of dental benefit management services including network management, claims processing, utilization management (UM), member and provider call center, provider credentialing and recredentialing, member outreach, and reporting and analytical support. This partnership will facilitate our ability to integrate medical and dental benefits more effectively, as we will leverage the collective experience of our two organizations to develop and maintain a robust and seamless delivery model for Nebraska Heritage Health that includes accountability at all operational levels.

Developing a Comprehensive Network to Expand Access to Care

Our dental partner's Provider Relations team has prior Nebraska experience, including familiarity with the dental delivery system and the unique needs of the population. We will leverage this knowledge to build a statewide network to deliver all covered services included in SOW V.E, and contract with required provider types, including critical access providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Indian Health Service Clinics, and the University of Nebraska Medical Center. Our dental partner also has extensive experience building comprehensive statewide Medicaid networks in short implementation timeframes. We have submitted a comprehensive dental network development and management plan included as Attachment V.I.33-1: Plan for Developing an Adequate Network, that is a blueprint for building our dental provider network and contains strategies for recruiting and retaining providers, identifying, and addressing network gaps, planning for future needs, improving timely access to care, and improving network quality.

Using a data-driven approach, our dental partner's Network Managers will continuously monitor our network to proactively verify compliance with the time and distance requirements using various mechanisms, including but not limited to: Geo Access Reports, reports on provider open panels and offices closed to new members, utilization data at the primary dental provider level, member reported access issues and data on member access-related grievances, reports on out-of-network utilization and reports on voluntary and involuntary provider terminations.

We will also leverage relationships with the following entities to enhance our network:

- **FQHCs.** Since FQHC sites serve members residing in federally defined medically underserved areas, contracting with them enhances access to dental care for the most medically vulnerable members. In addition, many FQHCs offer urgent clinics with same-day access to dental services, as well as extended office hours. We leverage key staff at FQHCs, like Dental Chairs to help promote oral health education and access. We will partner with FQHC's, including OneWorld, Charles Drew, and Blue Stem to increase dental outreach to members and increase the percentage of patients who receive oral health services at FQHCs, aligning with Nebraska Healthy People 2020 goals.
- **Providers in Contiguous States.** To allow for the closest possible service points, our network will include providers from contiguous states. We will also expand member access based upon member feedback using single-case agreements.
- **Scholarships.** We will offer scholarships to Black and Native American dental students, dentists and dental specialists enrolled at the University of Nebraska Medical Center School of Dentistry and Creighton College School of Dentistry who commit to practicing for five years in underserved or Tribal areas throughout Nebraska.

Innovative Dental Benefit Management Experience

Healthy Blue will actively collaborate with our dental partner to assure that dental benefits are highly coordinated and integrated across the member's full scope of needs. Our programs are designed to be holistic, patient-centered, and inclusive of dental benefits and services when screening, assessing, care planning, and monitoring our members' care. We have extensive experience working with integrated medical data and will apply this approach and experience to manage the whole member, improve health outcomes, and lower costs. Our fully integrated programs support members' total physical, behavioral health (BH), and dental needs and includes joint

operations, joint clinical meetings and committees, and interdisciplinary teams that facilitate the identification of member needs and implementation of needed care to close gaps. These integrated teams use shared data, reporting, and shared goals. We will invest in implementing strategies that support whole person health and complement the goals of DHHS. We will leverage shared analytic claim data to proactively identify potential medical needs from specialized providers and identify trends within targeted populations. Successful programming from affiliate markets that support a culture of good oral health include:

Teledentistry

Teledentistry offers an additional intervention for all members and is an especially valuable tool in rural communities by providing on-demand access to preventive and urgent care services both during and after business hours. [redacted] During business hours, on-demand teledentistry allows members with an urgent need to access a teledental appointment with a staff dentist. It is also a tool for individuals with disabilities, as teledentistry allows us to identify what care is needed so it can be coordinated effectively. We plan to deploy teledentistry through community access points like public libraries and schools in areas where there is limited access to broadband.

Teledentistry also expands access to dental screenings and preventive care for underserved populations by helping members who face barriers, such as lack of transportation or living in an area with limited dental providers. Through triaging and providing early evaluations, providers can improve outcomes, decrease the overall cost of care, and reduce ED use. Additionally, contact through teledentistry has been found to help improve HEDIS® scores and well child screenings. Following teledental visits, we will refer the member back to their Dental Home to assure continuity of care. Finally, teledentistry is a way to re-engage non-utilizing children and drive them to their Dental Home. [redacted]

Dental Home Program

A key strategy in offering coordinated and integrated dental care is our use of the Dental Home program, which emphasizes the importance of members receiving their first dental visit and well child screening beginning at age one. All members will be assigned to a Primary Care Dentist (PCD), and we will monitor PCD performance through quarterly Provider Performance Reports and tracking measures such as Annual Dental Visits (ADV) for ages one-20. We will identify HEDIS-eligible members, share the list of members with providers, and will offer providers financial incentives to further encourage EPSDT screenings and other preventive services. To help PCDs improve their performance, we will proactively identify members in their panel who have care gaps, including members who have missed EPSDT screenings.

The member's relationship with their Dental Home is continually reinforced. In the welcome packet and onboarding process, members receive information about their Dental Home and how to change it. Members are provided with ongoing communication about using their Dental Home, including through text messages.

Our unique Dental Home program provides high-quality dental care with an emphasis on prevention and control of oral diseases, where PCDs and PCPs collaborate, supported by data exchanges from medical and dental teams. Examples of collaboration include sharing diagnostic information with our dental partner, which will be shared with dental providers using our dental partner's portal. Dental providers can tailor their treatment planning based on the member's physical health needs and capture data on the patient (blood pressure, glucose testing), which can be shared via our portal. Through our Dental Home program, we will improve each member's dental care access, coordination, and experience because the members establish a trusting relationship and regular regimen with a PCD who knows their history and understands their specific care needs.

Healthy Blue Affiliate Dental Home Program Increases ADV Rate

In an affiliate market in 2020, our Dental Home Program drove a **121% increase** in the ADV rate in the month following member notification of assignment to a dental home, when compared to prior months.

NE_HH22_AffiliateDental_28_COB_01

Mobile Dentistry

Healthy Blue understands the critical role mobile dental units play in the delivery of dental services, especially for members living in remote areas. As we have done in affiliate markets, we will organize events, such as bringing mobile dental services to a high-volume PCP office on a clinic day or introducing mobile dental units to schools in communities with the greatest needs. Further, we will partner with organizations such as Midtown Health Center FQHC, in support of their existing mobile dental unit and OneWorld Community Health Center to deploy mobile dental services to areas where we observe trends in members missing preventive care visits and areas where achieving access standards can be challenging.

Oral Health Task Force

As we have done in affiliate markets, we will implement an Oral Health Task Force to increase integration between medical, BH and dental providers. Healthy Blue's Chief Medical Officer, BH Clinical Director, and Dental Director will collaborate to refine and coordinate our overall oral health strategy and to help facilitate members' access to comprehensive, whole person health care. The task force will develop strategies to integrate dental care and primary medical care.

Improving Member Outcomes

Healthy Blue will use multiple methods to promote improved outcomes for member dental care, including:

School-based Education Efforts

We will employ a variety of school-based efforts to increase education about and access to oral health services, a practice we have leveraged successfully in affiliate markets. Schools can play a vital role in helping to drive members towards the care they need, which can help to promote the Nebraska Healthy People 2020 oral health goal to decrease the number of third grade students with untreated tooth decay. We will conduct an analysis of membership to identify the greatest areas of need, will target Title one schools, and will work with existing school-based providers to collaborate on oral health education and screening and preventive services. ***In 2021, our affiliate partnered with Liberty Dental and provided 71 community events promoting the importance of dental health in another market.***

Provider-facing Interventions

In addition to ongoing education and orientation activities, we will employ the following interventions to expand access to and improve the quality of dental services:

- [redacted]
- [redacted]
- **Provider Education.** Educational information will be made available remotely via our dental partner's provider website, provider portal, live webinars, and on-demand learning modules.
- **Responsive Committee Structure.** We will conduct NCQA approved provider satisfaction surveys to help identify trends, gauge provider satisfaction, and identify areas for improvement. Results will be reported to the Quality Management and Improvement committees to help determine areas requiring intervention and will conduct interventions when needed. The results of interventions will also be reported in the quarterly Dental QAPI.

BRUSH VBP Statistics in an Affiliate Market

44% of total child Medicaid members are served through a provider enrolled in the BRUSH program.

88% of moderate and high-risk children identified through the BRUSH program are returning to their Dental Home for follow-up treatment.

NE_HH22_BRUSH_VBPStat_28_COB_01

Public Health Department Pilot

In collaboration with other MCOs, Healthy Blue will partner with the Nebraska Association of Local Health Directors (NALHD), for their Community Oral Health Expansion Program. This initiative is intended to maximize the use of Community Health Workers (CHWs) and dental hygienists as preventive care resources to Medicaid and other patients by expanding the capacity and capabilities of Community Dental Disease Prevention teams in rural Nebraska Local Health Departments (LHDs).

Member Engagement to Promote Service Utilization

In addition to reminding members about dental benefits during new member welcome calls, Healthy Blue will offer oral health education and outreach at community fairs and events, schools, and with community organizations that also serve the Medicaid population. We will offer dental screenings and provide basic preventive services through our member Welcome Rooms and by bringing mobile dental services along with other mobile immunization/other medical services. Our member Welcome Rooms in Omaha, Scottsbluff, Norfolk, Kearney, and Lincoln are member-facing spaces where we support their goals and encourage self-management and new health behaviors. We will also conduct member satisfaction surveys of dental services. ***Our affiliate partnered with Liberty Dental and achieved the 90th percentile for Quality Assurance Reporting Requirement dental scores.***

We also solicit input from member advisory boards in affiliate markets. This collaborative relationship drives increases in the number of members accessing preventive dental care and maximizes the integration of oral health with the physical and BH care of members.

Leveraging Data and Offering Incentives to Engage Members in Their Dental Care

By leveraging appointment tracking data in innovative ways, we will identify members for proactive outreach to remind them of available rewards for completing an ADV and when they are due or overdue for regular dental care. Further, we will collaborate with our transportation and dental partner to share data and provide Non-Emergency Medical Transportation (NEMT) information to educate providers on how we can coordinate NEMT services for members. We will also encourage providers to identify members who have missed their dental appointment so that we may educate the member on the importance of regular care, help them reschedule their dental appointment, and book transportation if needed.

No. 24

Mental Health Parity and Addiction Equality Act Compliance, Evaluation, and Measurement

As required in the SOW, Section E, Number 3, Healthy Blue complies with the Mental Health Parity and Addiction Equity Act (MHPAEA). Since the passage of the MHPAEA in 2008 and the release of Medicaid-specified rules for the Act, our parent company has established an enterprise-wide comprehensive and collaborative approach across all its Medicaid affiliates to ensure parity for our members. We follow parity guidance as it is issued under the MHPAEA and any affiliated State regulation to facilitate alignment between State law and the MHPAEA, whenever required.

[redacted] Our enterprise-wide parity program measures, tracks, and addresses compliance in the following core areas:

- Requirements pertaining to Quantitative Treatment Limitations (QTLs)
- Requirements pertaining to Non-Quantitative Treatment Limitations (NQTLs)
- Requirements pertaining to prescription drug benefits
- Requirements pertaining to annual and lifetime limits
- Disclosure requirements established under the MHPAEA

In addition to the previously referenced core MHPAEA compliance areas supported by our PGC, our Healthy Blue MHPAEA Compliance Workgroup — operating under the guidance of our compliance officer, who is supported by BH and PH staff — also monitors and validates that:

- Appropriate and comparable medical management techniques are applied to mental health or substance use disorder (SUD) benefits no more strictly than the medical management techniques that are applied to medical and surgical benefits
- Healthy Blue is in compliance with MHPAEA for any benefits offered by Healthy Blue to members beyond those specified in the Medicaid State Plan
- Criteria for medical necessity determinations for mental health or SUD benefits are available to any current or potential member, or contracted provider, on request
- Reasons for any denial of reimbursement or payment with respect to mental health or SUD benefits is made available to members
- Out-of-network coverage for mental health or SUD benefits will be provided when made available for medical and surgical benefits
- Annual dollar limit on mental health or SUD benefits are not imposed per 42 CFR 438.905 (b), and any financial, quantitative, or non-qualitative limits in force are applied consistently for medical/surgical and mental health/SUD benefits per 42 CFR 438.910
- An NQTL for mental health or SUD benefits in any classification is not imposed unless, under the policies and procedures of the MCO, Prepaid Inpatient Health plan or Prepaid Ambulatory Health Plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards

To further assure compliance, we assess approved and denied claims and appeals quarterly. Reporting separates mental health/SUD and medical/surgical benefits. QTLs, NQTLs, and annual/lifetime limits are assessed and reported in a format authorized by an MLTC annual mental health and SUD parity report. Additionally, we update our policies and procedures annually and as needed in response to new statutory, regulatory, and policy guidance. We review any significant changes to operations or policies that are likely to impact MHPAEA adherence prior to implementation.

The previously referenced collaboration between our PCG and the Healthy Blue MHPAEA Workgroup generates an annual mental health and SUD parity report that we provide to Nebraska Medicaid showing the design, application, and delivery parity results. Additionally, we conduct an assessment of managed care practice impact on benefit parity in areas such as prior authorization, reimbursement rate setting, and network design.

Parity Compliance Approach

Utilization Management. Our medical necessity criteria and prior authorization requirements for mental health and SUD benefits are not more restrictive than those for comparable medical or surgical benefits. Additionally, we take the following steps to assure compliance:

- We confirm yearly through monitoring and internal reviews that mental health benefits are on par with the comparable medical or surgical benefits.
- We confirm that medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques applied to medical and surgical benefits.
- We make medical necessity criteria for mental health or SUD benefits available to any current or potential member or contracting provider upon request.

We are committed to transparency in parity-related communications with both members and providers. We post our criteria for mental health and SUD medical necessity determinations on our online provider website, as we do for clinical criteria related to medical and surgical services. Both medical necessity criteria and policies and procedures for utilization management (UM)/utilization review are available to members on our website. We provide to both members and providers the reason for any denial of reimbursement or payment of mental health and SUD benefits using a formal denial notice, as we do for medical or surgical benefits. Our fully integrated care coordination process supports compliance with parity between physical health and mental health/SUD benefits, including when coordinating transitions of care for members going from a higher to a lower level of care and when making decisions to deny requests for a higher level of care based on medical necessity.

Network. We confirm that our provider networks for mental health and SUD are equivalent to or more robust than comparable medical and surgical benefits. We make available out-of-network coverage for mental health and SUD benefits when coverage within our network cannot meet the member's needs. We ensure appropriate and expedited support to meet the mental health parity needs of our

members in a manner that is parallel to the processes in our medical and surgical benefits. Of note, out-of-network coverage is also available for medical and surgical benefits when coverage within our network is not available.

Equal Financial Requirements. We confirm that a member is not required to undergo less expensive treatments before pursuing treatment suggested by a clinician or because they have not failed a lower level of care. Any risk sharing with providers for mental health/SUD services is comparable to medical or surgical services.

Subcontractors. All delegated vendors performing UM and care coordination activities complete an attestation related to MHPAEA compliance. Vendor contracts include the ability to audit policies and operations for compliance with MHPAEA.

Health Equity. Our parent company and Healthy Blue as an affiliate collaborate to make sure all members receive equitable, high-quality care. We recognize the impact that mental health parity has on health equity and evaluate the effectiveness of our parity program through the lens of health equity. Parity network analyses consider needs for culturally and linguistically appropriate providers. As an extension of our commitment, we are undergoing evaluation by NCQA and expect to receive a Multicultural Health Care Distinction.

Compliance Structure, Evaluation, and Training

Our defined compliance structure clearly establishes roles and responsibilities at an enterprise and affiliate level. This assures standardized evaluation techniques are applied for parity assessment. These well-defined premises combine with an emphasis on local leadership and provider training to support understanding and adherence to parity principles. Next, we outline highlights of our governance committee responsibilities, evaluation technique, and a brief synopsis of our training approach.

Parity Governance Committee. [redacted]

- Monitoring adherence to MHPAEA, including adherence by each individual health plan
- Providing constructive feedback to maintain/sustain parity compliance
- Reviewing/approving parity policy decisions
- Reviewing and monitoring corrective action plans arising out of regulatory inquiries/audits
- Reviewing cost of care initiatives to assure parity adherence is not impacted
- Evaluating internal processes and procedures
- Reviewing performance metrics

[redacted]

Evaluation. For evaluating outpatient subclassifications, multiple network tiers, lifetime/annual limits, and QTLs, we use the approach outlined under the Department of Labor's Compliance Assistance Guide. To evaluate NQTLs, we follow the guidance outlined in Table 5 of the Federal Mental Health Parity and Addiction Equity Filing. This approach requires a comparability and stringency analysis that gives equal weight to processes, strategies, evidentiary standards, and other factors.

The PCG reviews parity metrics for each of our individual health plans quarterly. The results of this review are shared with the QIHEC and QMC.

[redacted]

No. 25

Member Services Processes

Healthy Blue prioritizes earning trust with our members and supporting health literacy through comprehensive customer service including call centers, digital resources, and in-person support at one of five Welcome Rooms throughout the state. Under the direction of the Healthy Blue Member Services Manager, Jodi Payne, we maintain a single, statewide toll-free number that meets all requirements in the contract. Our toll-free number provides members with immediate access to our Member Services Call Center, 24-hour Nurse Helpline, and behavioral health (BH) service line that links members to the services, supports, and resources they need when they need them and in a manner that they can understand them.

Upon enrollment, we inform all members about the Member Services Call Center, an important source of information that will help them navigate the health care system. The services offer include:

- Changing primary care providers (PCP)
- Requesting a new ID card
- Getting answers to questions regarding their benefits and how to access the services, supports, programs, and resources available to them
- Resolving concerns or complaints about their care, including grievance and appeals information
- Helping them with appointment scheduling and locating resources to address social determinants of health (SDOH) needs

All calls are monitored to assure members receive all the information and support they need in a timely manner. Calls and issue resolution are tracked, and compliant with all state requirements. [redacted] To encourage the best engagement, we evaluate our Member Services Representatives (MSRs) based on the quality of their call interactions and not according to call volume or duration. Healthy Blue's Member Services Call Center is staffed by 58 MSRs serving Heritage Health members. All our MSRs receive training on the specifics and nuances of the Heritage Health program and Nebraska population.

In addition to the MSRs in our call centers, Member Outreach and Education Representatives will be available at our Welcome Rooms. Five Welcome Rooms, located across the state, were established to better meet the needs of our members, by providing them with face-to-face support. Each Welcome Room is equipped with meeting rooms that members can use for private telehealth appointments with their provider or a meeting with a member of their care management team. Each of the rooms have public computers that can be used by members to search the internet, apply for benefits, locate employment opportunities, and get connected to other essential community resources. The Welcome Room staff are available to assist members to complete job applications, view their eligible benefits, request transportation assistance, obtain a replacement member ID card and assist with locating or changing their medical or Dental Home. Our Welcome Room staff can also make referrals to our care management team for any member who requests additional assistance or for those who may benefit from this service.

Customer Service Training

In Nebraska, we hire for compassion and train for skill. Employees who directly interact with members are critical to building and maintaining trusting relationships in each community we serve. [redacted] To maintain the most responsive and efficient MSRs, our training program highlights the distinctive characteristics of the Heritage Health program. All Member Services new hires receive the Nebraska Medicaid Market Overview, which covers culture, demographics, geography, and economy of Nebraska. They also receive the Nebraska Cultural Sensitivity training course, which includes the location and pronunciation of major cities and towns; statewide and individual county demographics, including languages spoken in the home; American Indian Tribal lands and SDOH of Tribal members; and SDOH of predominant Nebraska populations.

Our Member Services Call Center training program provides numerous expert-developed, customized trainings that accommodate various formats, media, and allows for flexibility in schedules. In addition, we develop our own program-specific, customized trainings that promote greater understanding of the program, processes, and Nebraska-specific population needs.

Beginning with new hire training, we educate MSRs on our patient-centered approach to care, best practices, and strategies for engaging members and families. Throughout their employment, we provide continuous training, coaching, and supervision to support employees in consistently applying these principles when serving our members. We teach employees to demonstrate our values through the choices they make in daily interactions with each member, and that a single action by any one employee impacts the customer experience. We conduct our training in a controlled environment with supervision and coaching, including listening to recorded and live calls to provide real-time feedback, followed by an evaluation period.

Our training curriculum and resources employ several educational strategies designed to accommodate different learning styles, including written materials, interactive class discussions, and computer-based tutorials, supporting MSRs to build the skills necessary to deliver knowledgeable and accessible assistance and services to our members.

Initial Training

All employees serving members attend an initial orientation about Healthy Blue, HIPAA privacy compliance requirements, the Heritage Health program, and our Nebraska membership. [redacted] ext, the MSR returns to the classroom and learns additional skills that build on the first segment. Our training process includes the following components:

- **Classroom Training.** An experienced trainer who has in-depth knowledge of Heritage Health members and covered benefits and services facilitates a multi-week MSR training program.

- **Systems Training.** MSRs are also trained to use our knowledge management system and integrated desktop application for real-time access to program requirements, covered services, eligibility, and claims data. Training includes:
  - **Nesting Calls.** Live calls are received in the production environment to acclimate MSRs to system tools and resources.
  - **Nesting Huddles.** Call center leaders meet with MSRs daily to discuss situational events they encountered for clarification or resolution.
  - **Quality Review.** During the nesting period, we increase call monitoring to assure MSRs are performing to our standards.

We hire staff with appropriate education and experience in serving Medicaid members. As part of our onboarding process, every staff member participates in Nebraska-specific trainings. Such trainings include an overview of the Nebraska market and a cultural sensitivity module focused on Nebraska's populations. We develop and update these modules through proactive analysis of our ongoing experience in the state and through collaboration with key community-based organizations. Our MSR training program assures that staff are trained to efficiently respond to any question or concern, as outlined in Table V.F.25-1. Our structured classroom-based curriculum includes modules that educate MSRs on the role of the PCP; fraud, waste, and abuse; cultural competency and how to recognize callers with language barriers; local providers and resources; and other topics. The curriculum also includes priority topics such as trauma-informed care, suicide prevention, and opioid use disorder.

Prior to interacting with members and families, MSRs must successfully complete formal training on recognizing and responding to member crisis calls, including how to recognize suicide warning signs, triage situations, and identify appropriate actions to take.

We track, monitor, and report on completion of orientation, compliance, and specific annual and staff trainings through our training program, which is overseen by a dedicated manager. All training records are also available to our Contract Compliance Officer, Christine Cole. We maintain comprehensive documentation of staff training, curriculum, schedules, and attendance. All our training includes timeframes for completion and tests for individual and organizational comprehension.

Depending on the training and mode of delivery, our monitoring mechanism to verify completion include completed training schedules from managers and system records of web-based trainings.

Ongoing Training

Our ongoing training program assures that all staff working directly or indirectly with our members and providers are fully trained and knowledgeable in their areas of focus, as well as any program changes, prior authorization modifications, and the appropriate identification and handling of quality-of-care concerns. Our training platform capabilities provide a comprehensive way to alert, track, monitor, and assure staff complete required trainings for their positions and ongoing or refresher courses as required or indicated.

When we introduce a new product or system, we make certain MSRs receive training and fully understand it. We also offer courses to enhance service skills and professional development, such as:

- Identifying and responding to customer styles
- Providing Member Services over-the-phone versus face-to-face
- Understanding how to uniquely serve each member

- Understanding the defining moment in a member interaction
- Implementing standards to stay in tune to member needs and expectations

Other training topics include quality, best practices and opportunities, bulletins, advance review of member and provider communications, and program and benefit changes. Staff also receive ongoing training on handling calls received; how to assist callers with accessing medical services; cultural competency (including diversity training, Nebraska geography and location pronunciation, and cultural references); and assisting members with LEP. We offer these trainings through numerous methods such as online, in-person, group, and individual trainings.

We strongly believe that compassion, patience, and empathy are important characteristics that all MSRs must possess and prioritize these personality traits during the hiring process. We also offer specialized training, such as our CARE Service curriculum, to enhance the ability of our MSRs to connect with members and provide a positive Healthy Blue experience.

CARE training assures our representatives:

- **Connect** with the member on a personal level and show genuine interest
- **Always** communicate with confidence and knowledge
- **Resolve** inquires by taking responsibility and presenting solutions
- **End** with a positive lasting impression

[redacted]

Call Routing

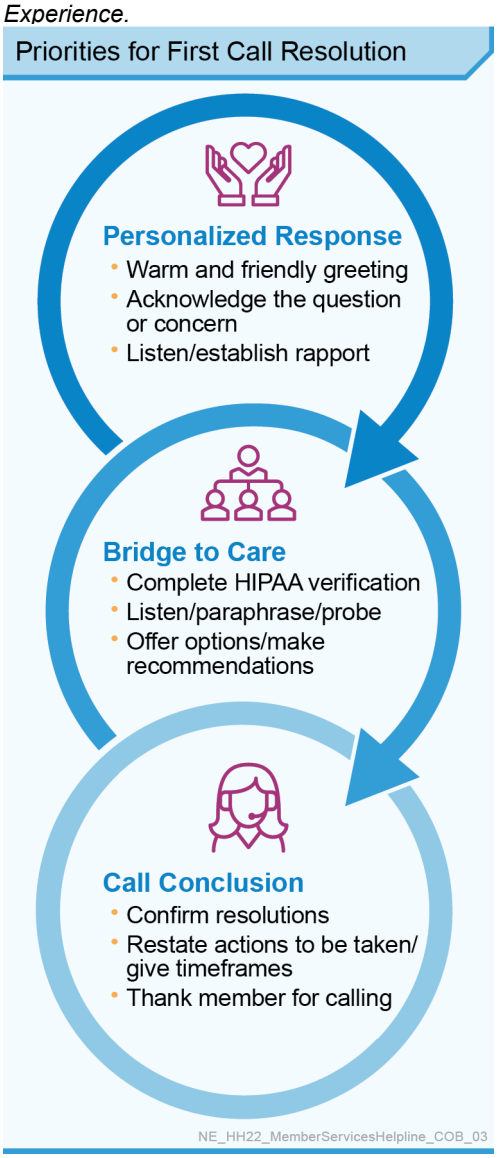
Healthy Blue maintains statewide toll-free numbers that meet all requirements detailed in SOW F.2. These toll-free lines include our member services telephone line (Member Services Call Center), our Toll-free Nurse Helpline (Nurse Helpline), and our behavioral health service line.

These toll-free lines are often the first point of contact for new members and a valuable opportunity to build a positive, trusting relationship with members by responding to their inquiries and concerns in an efficient, respectful, and compassionate manner. As shown in Figure V.F.25-1, Our goal is first call resolution, and while our MSRs can resolve most member needs during a first call, we have proven protocols and systems to route callers to internal or external resources, when necessary.

All incoming member calls initially route to our interactive voice response (IVR), which uses natural language, skills-based routing to direct callers to the right resource equipped to provide timely and accurate responses to a range of inquiries. Through the IVR, members can opt to complete selected tasks, such as requesting a member ID card, without the need to speak to an MSR. At any point during an interaction with the IVR, members can opt to speak to a live person via the Member Services Call Center (during business hours), Nurse Helpline (24/7/365), or BH service line (24/7/365). To pinpoint a caller's individual needs, MSRs use our integrated desktop platform to guide them through a series of questions with assistance from our powerful call center platform. This platform rapidly accesses and displays all data related to the member's benefits, such as their PCP, services utilization and claims history, enrollment detail, authorizations, and other health insurance coverage. Our MSRs have access to our knowledge management tool that enables them to search for applicable program documents through a search engine.

MSRs proactively initiate internal call routing when indicated, such as transferring calls to our CM team for members with health-related questions or with identified health concerns from a Health Risk Screening.

Figure V.F.25-1. Driving to Improve the Member Experience.



[redacted]

WHOLE STATE WHOLE HEALTH WHOLE PERSON

Our MSRs are trained to recognize signs that a member can benefit from speaking to one of our clinical call center staff. For example, our BH service line staff are trained to listen to callers for signs of distress, depression, anxiety, or intent to hurt themselves or others. If a member is experiencing a crisis, we conference a BH Clinician in on the

call to address the crisis in real time. In these and other circumstances, our desktop platform fully supports warm transfer capability through the MSR's computer screen. When internal staff such as Care Managers receive warm transfers, they have access to the necessary information through our Health Intech platform to resolve issues expeditiously and prevent the caller from having to repeat their request.

Access to Supervisory Staff During a Call

Our MSRs follow proven Healthy Blue protocols relating to call de-escalation and escalation to a supervisor. They are trained to remain calm, patient, and empathetic and to practice active listening during all calls, including those in which the caller expresses anger or frustration or requests to speak to a supervisor. In this case, the MSR gathers information about the caller's circumstances and needs and attempts to resolve the caller's issue using all available resources. If the MSR is unable to resolve the situation and the caller still wants to speak to a supervisor, the MSR warm transfers the call to a supervisor for assistance.

How and When Information Is Made Available to MSRs

Our system uses natural language, skills-based routing to direct callers to the right resource equipped to provide timely and accurate responses to a range of inquiries. Members who either do not have or do not know their member ID number are asked the reason for their call and are directed to the right resource. At any point during a call, members can opt to speak to an MSR, Helpline Nurse, or BH service line representative and are connected automatically.

Calls are answered in the order they are received, on a rolling basis. Our MSRs answer calls using a consistent approach. For family members, caregivers, and other authorized representatives calling on a member's behalf, we encourage them to complete and return a HIPAA authorization form that provides a one- year authorization to call on the member's behalf.

As the MSR confirms the reason for the member's call, they are assisted by our powerful Member Services platform. This platform rapidly accesses and displays all data related to the member's benefits, such as assigned PCP, services utilization and claims history, enrollment detail, authorizations, and other health insurance coverage. In addition, our MSRs have access to our knowledge management tool that enables them to search for applicable program documents via a search engine.

This knowledge repository includes processes and procedures to handle a variety of incoming calls and a daily "announcement" functionality that posts notification of benefit or other program changes. The repository checks for updates in real time, making sure MSRs have the most accurate information at any point in time. Both our Member Services platform and knowledge management tools were designed to help us resolve multiple issues in a single call, guiding our MSRs through various needs and concerns and providing member-specific prompts such as a reminder to complete the initial Health Risk Screening.

Prior to ending a call, the MSR confirms the member's issues have been resolved, asks if they were able to help the member with all the member's concerns, and requests whether there is any other assistance needed.

Handling Calls with Members with Limited English Proficiency and Those Who Are Hearing Impaired

In 2021, these were the top 10 languages by volume for which our members requested over-the-phone interpretation at no cost

1. Spanish
2. Arabic
3. Karen
4. Somali
5. Nepali
6. French
7. Amharic
8. Vietnamese
9. Burmese
10. Karenni/Kayah

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Language barriers should never be an impediment to accessing health services or engaging in health care. When members call our Member Services Call Center, they may select to hear our menu of options in English or Spanish. If the caller does not choose English or Spanish, our system automatically routes the caller to a representative who is trained to recognize language needs and quickly connect the member to an interpreter.

For members with LEP, interpreters are immediately available through our language line at no charge. The language line offers certified interpreters in more than 230 languages who are trained in health care terminology. [redacted]

For members who are deaf, hard of hearing, or have a speech disability, we use national Telecommunications Relay Services (TRS) to facilitate communication. Members and families can initiate a three-way conversation by dialing 711 through a text telephone (TTY) or another device. Our MSRs are trained to identify and respond to calls received via TRS services.

Assuring Quality and Accuracy of Information Provided to Members

We developed our Member Services Call Center quality program to do much more than assure call quality. The program takes a consultative approach to build the skills of our MSRs, identify trends and training opportunities, and coach individual team members with identified opportunities for improvement. Call Quality Analysts evaluate calls and electronic communications using an analytics-driven approach, based on MSRs' performance, trends, and overall error risk.

Newly hired MSRs receive live observation sessions where a Call Quality Analyst sits side-by-side with them and provides "in-the-moment coaching" during member contacts. For more tenured MSRs, an analytics-driven approach identifies those that would benefit most from focused audits and coaching. Call Quality Analysts provide these live observation sessions and coaching. At the end of the quarter, the Call Quality Analyst reviews the MSR's performance to determine if continued focus is needed.

Healthy Blue also conducts post-call surveys to evaluate member satisfaction and to assure that our MSRs are treating all members with courtesy and respect. Since January 2021, we have completed 1,505 surveys with ***courtesy and respect scoring at 92%***. In addition, quality partnership meetings held monthly between the Quality Improvement team and the Member Services Call Center Management team discuss quality results, including areas needing further development, and brainstorm on how to assure continuous quality improvement.

Monitoring and Adherence to Performance Standards

In accordance with the contract, we monitor and report on a range of key Member Services Call Center performance metrics during business and non-business hours and use this data to continuously improve the member experience. Our metrics track things like call volume, calls received and answered within 30 seconds, calls abandoned, first call resolution rate, after-hours calls received and returned the next business day, and other indicators. These are presented in a dashboard form and provide an all-inclusive picture of our performance against Heritage Health standards and help us maintain adequate staffing levels. Healthy Blue monitors all call center metrics in our Service Quality Committee to maintain appropriate oversight and compliance.

We combine historical call volume and average handle time data with membership projections and other sources of data such as seasonal variations to produce a forecast of monthly call volumes and average handle times. The forecasts are developed in half-hourly intervals, by day. From the forecasts, we create Member Services Call Center staffing schedules. We review and adjust forecasts at regular intervals to account for changes in membership, actual performance, upcoming significant program or benefit changes, and seasonal factors.

For example, call volume is higher at the end and beginning of each month because that is when larger volumes of member ID cards are sent. It is also higher immediately following a holiday. We also track top call reasons to help identify training opportunities, update member education and outreach plans and materials, and make system or operational changes. The top call reasons for members include benefit questions, pharmacy questions, and requests to change PCPs. We periodically review top call reasons to identify new training or educational opportunities and to resolve issues proactively by sharing lessons learned. For example, if after sending a member communication announcing a program change, we still receive a high volume of calls, we may learn that we sent the communication too early before the change and adjust our communications schedule for similar mailings in the future. Our staff are very familiar with the MLTC's reporting requirements and submission procedures. We will continue to create and submit Member Services Call Center Performance Reports and manage our operations to comply with MLTC's performance level requirements.

Interacting with Other Organizations

Healthy Blue MSRs are trained and equipped to solve most member needs internally. Our integrated desktop platform facilitates this process by displaying member information and other resources in an organized, simplified fashion so the MSR has immediate access to the information necessary to meet the member's needs. The platform also captures detailed call documentation that expedites potential follow-up action by internal staff, such as our care management team. When a member calls the Member Services Call Center with an SDOH need but does not warrant the more intense intervention of care management, the MSR will provide the member with a warm transfer to the Community Connected Call Center. Our MSRs are trained to "warm transfer" (connect the call while remaining on the line to introduce the member and the situation) callers. In this manner, we make sure members are connected to necessary resources and assistance, in particular leveraging our Community Resource Link.

If necessary, our MSRs can transfer members to an external party (provider or dental subcontractor, another MCO, or a community resource). The desktop platform displays contact information for resources, such as our subcontractors or community-based organizations, to expedite transfers to those resources. In the case of enrollment concerns, an MSR calls into the Nebraska Medicaid Eligibility System (NMES) to verify a member's eligibility.

Our Healthy Blue Welcome Room staff are also able to identify or support the state in member outreach initiatives and assuring accurate member information. Healthy Blue was able to identify a file issue related to the foster care population. Members in the foster care system did not have accurate Power of Attorney (POA)/guardian information in our system. Our Welcome Room staff worked with Nebraska's foster care agency to confirm that we had the correct guardian information. This helped sort out outreach, benefit, and claims issues for this vulnerable population and the plan. Inaccurate identification of POA also impacted other members. In conducting outbound call campaigns, completing PCP change request forms, and working with walk-in members, the Welcome Room team would at times identify that our system did not have accurate POA information for the member. At the request of the state, the team kept a spreadsheet of members that needed a confirmed POA/guardian. That spreadsheet would then be periodically emailed to the State to confirm POA or guardian for that specific member and confirmed in our system.

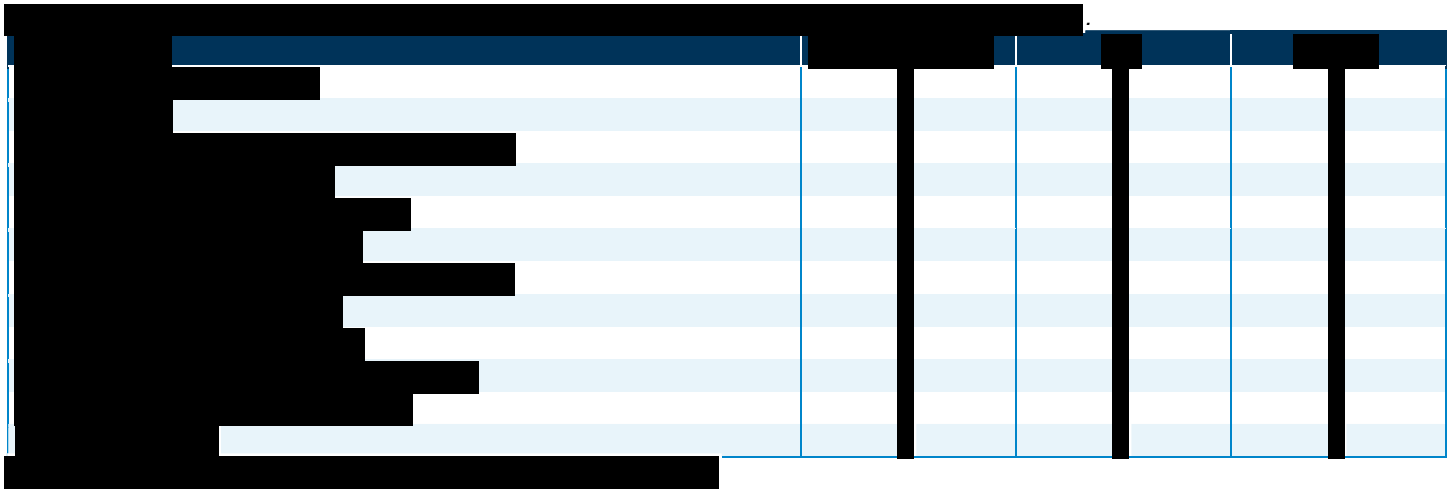
After Hours Procedures

Our call center provides members with 24-hour access to our Nurse Helpline and BH service line that link members to the services, supports, and resources they need whenever they need them. All incoming member calls initially route to our IVR, which uses natural language and skills-based routing to direct callers to the right resource equipped to provide timely and accurate responses to a range of inquiries. Through the IVR, members can opt to complete selected tasks, such as requesting a member ID card, without the need to speak to an MSR. At any point during an interaction with the IVR, members can opt to speak to a live person via the Member Services Call Center (during business hours), Nurse Helpline (24/7/365), or BH service line (24/7/365). After-hours callers can leave a voicemail for non-urgent administrative issues, and those calls are returned the next business day.

Members also have 24/7 access through the member portal and Sydney to get information they need at any time. Sydney is our digital member engagement platform, accessible via the website or mobile app. It provides a digital ecosystem tailored to each member's preferences and health care needs.

Table V.F.25-2 outlines tasks handled through contact with our Member Services Call Center and how these tasks can be addressed (either directly by our MSRs, through the IVR, or through our web and mobile platform, Sydney). An "X" in the table represents items that can be completed directly in the designated tool. "Y" represents IVR menu options that are routed to the appropriate staff person for assistance.

[redacted]

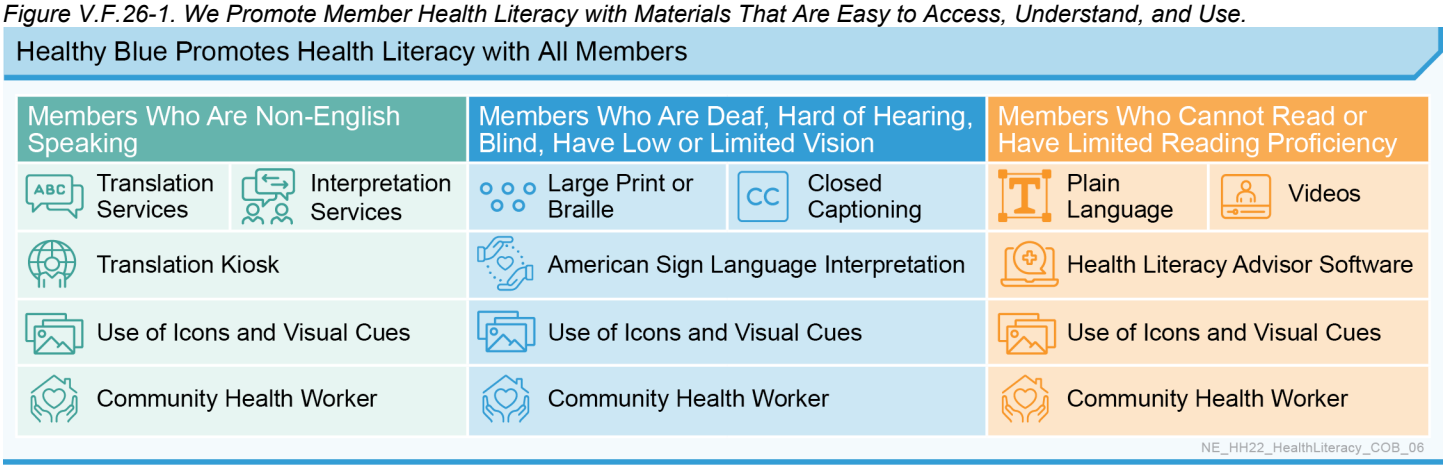


No. 26

We Develop Clear, Concise Materials That Members Can Easily Understand

We understand the importance of providing information in a culturally and linguistically appropriate manner and in multiple formats to make sure that members understand their covered benefits and services, how their health care program works, and how we will partner with them to meet their health and wellness needs. Figure V.F.26-1 depicts the many ways in which we make sure that members can access and understand the information they need. We recognize that these efforts are key to improving health literacy and promoting health equity among members.

Figure V.F.26-1. We Promote Member Health Literacy with Materials That Are Easy to Access, Understand, and Use.



Working with dedicated Clinical Health Promotion staff and with input from clinicians across our organization, we develop member communications, marketing collateral, and education materials to address health, wellness, preventive service recommendations, and targeted health issues. Our messaging is simple and informative. It includes information about eligibility, our provider network, the programs and benefits available through our health plan, and the importance of preventive care. Our materials are easy to read and concise, with short sentences, bulleted lists, and white space to break up and avoid large blocks of text. We are strategic in our use of descriptive icons and demographically appropriate imagery, and we avoid medical jargon when possible. We use icons to help members understand the text as well as culturally appropriate imagery. We solicit member and stakeholder feedback on materials (for example, in our quarterly Member Advisory Committee (MAC) meetings) to make certain our messaging is appropriate for Nebraska members and adjust it if needed.

To optimize readability and understandability of our materials and communications, we use evidence-based health literacy tools and principles. For example, we use the ***CMS Toolkit for Making Written Material Clear and Effective*** to help us create material that is most appropriate and easy to understand for members and use the ***Flesch-Kincaid Grade Level readability tool*** to measure the readability of the materials we produce to make sure they are at or below the sixth-grade reading level. We also use an innovative, interactive literacy software tool called the ***Health Literacy Advisor***, which replaces hard-to-read medical terms and phrases with plain language and scores documents on their general readability.

To make sure that the content and form of our member materials comply with federal and contractual requirements, we use our review process, known as the Collateral Materials Approval Process (CMAP). Through CMAP, all marketing materials for external distribution (verbally, written, or electronic) are reviewed by a multi-disciplinary team of subject matter experts and compliance staff before submission to MLTC for approval. We use an online tracking tool to promote consistency in the routing of materials for review and thorough documentation of each reviewer's approvals or changes. When submitting member materials to MLTC for approval, we include all details about how we arrive at the Flesch-Kincaid score.

Healthy Blue obtains approval from MLTC for all member-facing materials at least 30 calendar days before distribution, making sure to comply with all information requirements in 42 CFR 438.104(a). The same process applies when we make substantive changes to approved communications or when we want to refer to or use the MLTC or other state agency name or logo in member communications. We maintain documentation of MLTC approval of our member-facing materials and conduct ongoing reviews to make sure that MLTC approves all activities and materials and that the materials are distributed or made available in the approved format.

Digital and Social Media

In addition to our written materials, we use our website, mobile app, and social media to promote tips for healthy living, provide information about community activities, and help guide members to social services. We post State-approved member materials and other health information and resources on our public website in both English and Spanish to make these materials easily accessible. We share information via digital and social media about programs and services, along with company announcements. Our staff monitors these web pages for member feedback or suggestions. We enhance the reach of our digital information through visual improvements, refreshing content and consolidating information into user-friendly views. Our videos, posted on our public social media pages, are closed captioned and enabled with screen-reading capability for those who are blind or have low vision.

We Provide Member Materials in Alternate Formats That Meet Member Communication Preferences

Our members receive and process information in different ways, at different times, and through different means. Our communication strategy includes a variety of methods to make it easy for members to contact us when they have questions, need help, or would like to share a concern. Members can express their preference for receiving communications at any time. All communications are clear,

concise, accurate, at a sixth-grade reading level, incorporate visuals aids instead of lengthy descriptions, and are accessible for people with vision and hearing related disabilities.

To help members understand how to access their Healthy Blue covered services and benefits, we make all our member-facing digital materials on our public website and via Sydney Health (Sydney), our Healthy Blue mobile app. Sydney is available to members immediately upon enrollment. We send members their member ID card withing five business days of enrollment and hard copy written materials within eight calendar days of enrollment, exceeding the MLTC requirement of 10 days.

To reinforce the information included in our written materials, including our new member welcome packet, new member welcome call, and member handbook, and to help new members understand their covered benefits, we continually supplement communications by:

- Reaching members through outbound call, text, and email campaigns
- Using traditional media, digital media, and social media to communicate with members, including postcards, fliers, informational videos, and digital tools to supplement outreach calls, emails, and texts
- Extending our reach through community-based organizations, events, and Healthy Blue's education and outreach teams
- Enhancing member education and outreach through our care management programs

Alternate Formats to Assure Accessibility. We understand that linguistic appropriateness and cultural competency are powerful social determinants of health literacy as well as and health and wellness. Making sure that members receive information in their preferred language is integral to our health care strategy and promotes health equity.

HEALTH EQUITY

To accommodate members' linguistic preferences, we include taglines on our materials in Spanish, which is the prevalent non-English language in Nebraska, as well as large print. The taglines inform members about the availability of help with their health care questions, written translation or oral interpretation, and understanding the information provided as well as the availability of materials in alternative formats upon request at no cost. The taglines also include the 711 national telecommunications relay service TTY/TDD number designated for members who are deaf or hard of hearing.

Producing written materials in alternative formats is essential to increasing equitable access to health care. During face-to-face and telephone contacts, our member-facing teams make sure that members understand their right to receive materials in languages other than English and in alternative formats.

To support members who may need assistance with health plan communications, such as members who are blind or have limited vision; are deaf or hard of hearing; or have developmental disabilities, difficulties communicating, or limited reading proficiency, we offer a variety of supports, including:

- ***Providing materials in auditory translation, braille, and large-print format*** in English and Spanish and more than 230 other languages, upon request and at no cost to the member.
- ***Assuring all web and mobile app content***, including all documents posted on our member website, are compliant with Section 508 of the Rehabilitation Act as well as the more stringent Web Content Accessibility Guidelines 2.1 Level AA accessibility standards for individuals with visual limitations and those who use a screen reader or other assistive technology.
- ***Creating educational materials in video format*** and including closed captioning with all videos, webinars, and recorded presentations with audio made available to members in their original formats.
- ***Using infographics*** in materials such as our ***Health Tips*** fliers to sort information into easily understandable and concise segments for individuals who may have different literacy levels.
- ***Translating materials for members with limited English proficiency.*** Reaching all members in the language they speak is key to driving improved outcomes and health equity and to reaching all Nebraskans in the most appropriate way. At a member's request, we can and will translate all materials we create into more than 230 non-English languages. We work with vendors who employ ISO-certified translators for all non-English translations and apply a two-step back-translation of all documents along with an affidavit attesting to accuracy. All member communications include a statement in English and Spanish to call the Member Services Call Center for language assistance. Further, the public portion of our member website can be translated into Spanish at the click of a button. We post key documents in English and Spanish on the website and our Healthy Blue app powered by Sydney. We complete an annual Culturally and Linguistically Appropriate Services evaluation and are pursuing an NCQA distinction for Multicultural Health Care.

Our messaging is simple and informative. It includes information about eligibility, our provider network, the programs and benefits available through our health plan, and the importance of preventive care. In developing and distributing materials, we consider where individuals live; the language they speak; their literacy level, culture, and age; their ability to use technology; and their values, dignity, and needs.

We audit our written materials regularly to make sure that they contain current and accurate information. We continually develop and refine our outreach strategies and pay close attention to local and national health care issues that affect our communities so that we can offer new materials. We also review all written materials to develop culturally appropriate messages written in simple, clear language that are available in alternative formats, in accordance with program rules.

We Earn Awards for the Use of Plain Language in Our Materials

Since 2016, our parent organization, Elevance Health, Inc. (previously named Anthem, Inc.), has received five **ClearMark Awards of Distinction** from the Center for Plain Language recognizing its efforts to assure broad accessibility in communications for Healthy Blue members.

NE_HH22_ClearMark_COB_03

No. 27

New Member Welcome Approach

HEALTH EQUITY

Leveraging our experience serving Medicaid members in Nebraska and 25 other markets, we understand the value of engaging and educating new members immediately upon their enrollment so they can actively participate in reaching their health and wellness goals. Through multiple channels, we make sure that members and their families and caregivers can access and understand the entire continuum of Nebraska Healthy Blue benefits and services available. To improve the health literacy of new members and their access to our benefits, value-add services (VAS), and other programs, we create our enrollment materials and all other materials with simple, easy-to-understand language and culturally appropriate icons and graphics (shown in Figure V.F.27-1) delivering them to members as quickly as possible. We provide additional examples of our Healthy Blue member materials in Attachment V.I.30-1.

Welcome Packets

Our ***Healthy Blue welcome packet*** is designed to connect with members in a culturally and linguistically appropriate way. We send the packet in English and Spanish, and its content is written at or below a sixth grade reading level. The welcome packet can be translated upon request into more than 230 languages and formats such as braille, audio, and large print. Our overall goal in providing the welcome packet is to engage members and provide information to help them get started using their benefits. ***To make sure members can access Healthy Blue services and supports as quickly as possible, we send new members their member ID within five calendar days and our welcome packet within eight calendar days of receiving the daily 834 enrollment file, exceeding State requirements.*** In 2021, we mailed 26,499 new member Welcome Packets to new members, 1,329 of which were in Spanish.

In accordance with SOW F.13.b, we submit our welcome packet contents to the State for review and approval. The current version of our MLTC-approved welcome packet designed specifically for the Healthy Blue Program includes:

- Welcome flier, which includes information about finding the member handbook, searching the provider directory, registering on our secure member portal, and how to contact us
- Medically complex self-identification form
- Homelessness identification form for those who are homeless or at risk of becoming homeless
- Information on how members can get help and materials in multiple languages and alternative formats
- Quality postcard that describes how members can learn about our quality improvement program
- Notices, including nondiscrimination and HIPAA Notice of Privacy Practices

Figure V.F.27-1. Our Welcome Materials Make Access to Healthy Blue Easy.

With Our Welcome Flier, New Members Can Quickly Access Their Benefits

Welcome Calls

To supplement and reinforce the information included in our new member welcome packet, we deploy our new member ***welcome call*** and ***text message campaign*** to members within 10 days of sending new members the welcome packet. Welcome calls are often our first opportunity to communicate with members and welcome them to our plan, giving them an opportunity to ask questions about their covered services and benefits. We maximize the value of the interaction and fulfill SOW requirements by informing members that we will conduct a separate call to assist them in completing an initial Health Risk Screening (HRS) and connect them to services.

In accordance with SOW F.13.c, we submit our welcome call script to MLTC for review and approval. The current version of our approved script includes the following information:

- A brief description of the program
- Member confidentiality requirements
- Availability of oral interpretation and written translation services, offered free of charge
- Information about how to complete the initial HRS
- Patient centeredness and selection of PCP for preventive care
- Determination of pregnancy, chronic conditions, and barriers to accessing care, such as transportation
- Mention of upcoming outreach concerning their HRS completion
- Assistance with referrals, such as the supplemental nutrition assistance program SNAP and WIC

Alternate Methods of Welcoming All Members to Healthy Blue

In addition to the MLTC-required new member Welcome Packets and welcome calls, Healthy Blue welcomes new members using many innovative alternate methods and a variety of easy-to-use formats to meet the needs and preferences of all members.

Our Award-winning Mobile App

Sydney Health (Sydney) app, our member engagement platform, is available online or as a mobile app. With Sydney, new members can seamlessly access enrollment communications, the provider directory, and their member ID card, and they can complete their HRS, manage their prescriptions, and live chat with Member Services — all in one place. The digital member ID card is identical to our standard member ID card and improves convenience and access by allowing members to quickly view and share ID card information and important phone numbers at any time. It is an enhancement that is particularly meaningful for our Medicaid members in Nebraska,

who are increasingly using our mobile app and leveraging its capabilities, with Nebraska member engagement rates nearly double the rates of members in our other Medicaid affiliate markets.

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New Member Orientations

We are bringing back our ***new member orientations*** to our local Welcome Rooms. These quarterly orientations will offer new members the opportunity to attend virtually or, in the near future, in person. We will inform members about the orientation via text campaigns, postings on our website, and social media promotions. Members attending our orientations in person can experience one of our five Nebraska ***Welcome Rooms*** in Kearney, Scottsbluff, Lincoln, Omaha, and Norfolk. Local Healthy Blue employees staff these state-of-the-art Welcome Rooms and can provide answers to new member questions about their health care needs and plan benefits and make referrals to community resources. These will be quarterly and promoted through social media and our member website and app.

Our new member orientation program leverages the best practices of one of our affiliates and has seen a four-fold increase in new member participation. The enhanced program is designed to increase engagement and empowerment among members focusing on helping them get the most out of their health care, learning about their benefits, finding care, and knowing where to go when they have questions. The orientation events, held on different days and times (including weekends), will be interactive — giving members ample opportunity to ask questions and address concerns. Sample topics covered will include:

- Basic insurance terms
- Member ID card
- Covered services
- Value-added services
- Healthy Rewards program
- Disease Management programs
- Member website and mobile app
- HRS
- How to renew coverage

Member Handbook

Our Healthy Blue ***member handbook*** provides a practical and comprehensive guide for new members, their family members and caregivers, and others seeking information about covered benefits and services. It is based on guidance provided by MLTC and adapted to include materials specific to our plan and programs. Information included in the member handbook complies with 42 CFR 428.IO(f) and SOW F.5. We designed and maintain the member handbook with the knowledge that it is an important ongoing reference document relating to a wide variety of key information points. We make sure the most up-to-date version of the member handbook is available on our public-facing member website, and we identify recent changes to the member handbook at the beginning of the document. We will mail a member handbook to members at any time, by request and at no cost. Our new member welcome flier explains to members how to access the member handbook online, as shown in Figure V.F.27-1.

Member ID Card

The ***member ID card*** is essentially the information gateway to benefits. That is why we prioritize sending out ID cards to new members within five business days of enrollment. The member ID card includes all information required in SOW F.9.a. Additional information includes the name of the member's PCP, if selected, and important phone numbers such as our Member Services Call Center, 24-hour Nurse Call Line; transportation, dental and vision services information; and information about what to do in the event of an emergency. A TDD number is included for members who are deaf or hard of hearing. The member ID card includes prescription billing information or a separate dental ID care, as required, in accordance with SOW F.9.g-h.

We know it can be easy to misplace member ID cards, so members always have access to a digital member ID card through our secure member portal and Sydney app. The printed ID card mailed to the member includes a sticker that describes how to register for their secure online account. We issue replacement ID cards to members within 10 calendar days of notice that a member has lost their card or for other reasons that require a change. Figure V.F.27-3 depicts our digital ID card accessible through the app.

Member Website

Our ADA-compliant member website offers an entire section of information for new members and includes an interactive member portal, accessible via mobile device, that allows for two-way communication between members and Healthy Blue. Our MLTC-approved website contains up-to-date and accessible information for members including:

- New member section to welcome members
- Most up-to-date version of the member handbook
- Our doctor-searchable provider directory
- Informative member education videos to be made available in early 2023
- Contact information for Heritage Health, including a toll-free number for customer service and TTY/TDD number
- Link to Nebraska Medicaid eligibility
- Information on how to file a grievance and appeal
- Link to Heathy Blue VAS
- Tracking Healthy Rewards incentives

Figure V.F.27-3. With Our Digital ID, Members Always Have Their Plan Information on Hand.

The Digital ID Card Is Always at Members' Fingertips

NE_HH22_Sydney_DigitalIDCard_COB_03

Provider Directory

Knowing where to find providers in our network is perhaps the most vital information for our new members. Our welcome packet materials direct members to our online ***Find Care*** tool for information about our contracted network (including PCPs, specialists, hospitals, pharmacies, and behavioral health [BH] providers). With Sydney, our next-generation web and mobile digital health platform, members can seamlessly access and use the Find Care tool. Our materials also describe how to get help finding a nearby in-network provider and explain that members may request a hard copy of our provider directory at no cost by calling our Member Services Call Center or through a live chat feature within their secure online account. We will translate the directories upon request into other languages, braille, or large print. We exceed SOW requirements by updating our Find Care tool on a weekly basis to make sure members have the most current information about our provider network.

With our online, searchable provider directory, members can further refine their search results of providers by specialty, board certification, those accepting new patients, group affiliation, hospital affiliation, and specialty interests. In addition to traditional demographic information, our provider directory includes PCP gender, languages spoken, and Americans with Disabilities Act (ADA) accommodations and accessibility, Find Care includes a search feature for members to search for providers who volunteer or opt into disclosing and publishing race and ethnicity. As part of their online search for a provider that meets their preferences, members can enter their location information and view a list of providers that are best suited to meet their needs. The tool includes a map option with directions and information about public transportation options.

Videos

To accommodate members with communication preferences for audio and visual learning, by fourth quarter 2023, we will offer personalized onboarding videos, available in closed captioning, on various topics — including how to download the member app, understanding covered benefits and services, the QSG and member portal, how to select or change a PCP, understanding and completing the HRS, and proper use of ED services or urgent care — as enhancements to our new member onboarding experience.

Member Newsletter in Our Healthy Blue Blog

Key to our orientation process is making sure new members know where to get new and updated information on a continual basis. To reinforce the information included in our welcome packet, new member welcome call, member handbook, and other written materials, we supplement our communications with a member newsletter distributed in our blog, issued at least one time per quarter, that contains key information such as:

- Information on chronic illnesses and self-management
- BH information
- Flu shot and other timely prevention reminders
- Medicare Part D issues
- Cultural competency
- Tobacco cessation information and programs
- HIV and AIDS testing for pregnant women

No. 28

Influencing Member Behavior to Access Health Care Resources and Adopt Healthier Lifestyles

Healthy Blue will continue to provide members and their families with timely, clear, accurate, and culturally relevant information to support them in making educated decisions about their health. We educate members about staying healthy, maintaining chronic conditions for both behavioral health (BH) and physical health, medication management and pharmacy, and dental and oral health care needs. Our outreach and engagement strategy uses the pillars of Quadruple Aim to improve member experience of care, provider experience, the health of populations, and reducing the per-capita cost of health care. To influence member behavior to access health care resources and to adopt healthier lifestyles, we align our goals with the Nebraska Quality Strategy for Heritage Health to improve member outcomes, enhance integration of services and quality of care, encourage patient-centered and preventive care, and increase outcome driven community-based programming. We support members using multiple engagement strategies that begin when the member enrolls with Healthy Blue and continues with our ongoing outreach and engagement activities and direct support through population health and care management activities.

Connecting Members with Community Resources

Situation	Intervention	Outcome
A new mother needed rental assistance due to poor living conditions. Her landlord was not mitigating mold in the apartment or fixing a leak in her roof. To move out, the member would need to place another security deposit and first months' rent at a new apartment. She had enough to cover a security deposit, but not enough for the first months' rent.	In the Health Risk Screening (HRS) the member identified housing as a barrier. We assigned a Care Manager (CM) who reached out to the member to learn more about her story and offered to apply for a Flex Fund to supplement the money needed for the new apartment.	After completing the application for the Healthy Blue Flex Fund, the CM and member remained in contact until it was fully processed and approved. The new apartment received the funds, and the member has since moved out of the poor living conditions and into the new apartment with her baby. She received education about the additional services and support that the CM could provide and knows where to reach out if she needed help.

NE_HH22_ConnectingMembers_Q28_COB_03

Making It Easier to Make the Right Choices

We empower members to become active participants in their care. Our member communications begin with a new member welcome call, new member welcome packet, and ongoing calls and text messages to make sure members and their families understand:

- Their benefits and available programs, services, supports, and providers
- How to access needed services
- Who to contact when they need support
- How to complete screenings and assessments and how we can help

We communicate with members in meaningful ways, including in-person, by telephone, via traditional mail, and digitally through text, email, social media, and our innovative Sydney digital engagement platform. Our member messaging includes information about covered benefits, our provider network and programs, prevalent health conditions, medication management, oral health, treatment protocols, and the importance of preventive care. Our communications promote healthy living activities, support members in managing their conditions, promote available Healthy Rewards incentives and value-added services (VAS), and help close gaps in care by encouraging member and family participation. Our Community Relations staff currently provides state-approved health tips, and other state-approved printed materials that align with the theme of the community event we are attending.

In 2022, we will be hiring Community Health Workers (CHWs) to engage members. We identify the health and social needs of our members at every opportunity and with every interaction, including through initial and continual needs assessments, gathering information from providers, and mining demographic and claims data for potential risk based on members' race, ethnicity, and geographic location. This information helps us prioritize additional outreach and engagement strategies to quickly connect members to needed services and supports.

[redacted]

Accessing Member Information in Sydney. Sydney is a powerful digital ecosystem with personalization at its core, providing a tailored experience to each member based on artificial intelligence and machine learning. The more a member uses Sydney, the more it will learn a member's preferences, resulting in smarter recommendations about a member's health care needs. A member can ask questions via chat, use the menus, or have Sydney help a member navigate health care needs. It is flexible to cater to our diverse membership and personalizes each member's experience, including:

- On-demand videos on health care topics such as the role of PCPs and emergency department (ED) use
- Personalized member orientation videos

- Tools and resources customized to the member's health history and interests
- Checklists and questions to ask health care providers during appointments

In 2020, Sydney won the Mobile Star Shining Star award for Innovative COVID-19 Prevention or Response, demonstrating our effectiveness in health education. With Sydney, members can seamlessly access and use the Find Care tool to find a provider. Sydney offers easy-to-use care finder tools, including clear benefit details and health improvement programs in one simple, digital solution. Members can access our My Health Dashboard feature through the secure portal or mobile app. Members can identify areas to improve their health and set up action plans to meet and track towards their health goals. Members can choose when and how they obtain information on care pathways.

[redacted]

Incentivizing Members to Receive Preventive Care Through Our Healthy Rewards.
We have enhanced our Healthy Rewards program to be more engaging for members and advance the State's Quality Strategy priorities. Members can access the Healthy Rewards platform to enroll or redeem rewards via single sign-on from our secure member portal, Sydney, or receive phone-based support. Rewards include gift cards from well-known retailers; cards may be redeemed online or by physical gift card in the mail. ***Healthy Blue members most frequently earn incentives for adult well-visits, showing the power of incentives to promote effective utilization.***

We raise member and provider awareness about incentives and prioritize frequent, smaller rewards to maximize impact. Enrolled members receive health education information respective to their gender, age, health risks, gaps in care, and other demographics. We use bright imagery, personalized messages, and include a clear and simple "call to action." We offer Healthy Rewards incentives to improve health outcomes, promote primary and preventive care, foster personal responsibility, and encourage a healthy lifestyle. For example, our Healthy Rewards program encourages members and their parents/guardian to attend well-baby and annual child/adolescent well-visits, fill asthma medications on time, reduce unnecessary ED use, complete an initial screening, and seek BH care. We highlight these programs in our new member welcome calls, new member welcome packet, and community events. Our Member Services Representatives and CMs promote these programs during interactions with members. Our field-based outreach teams share incentive information with provider offices and community partners, such as at schools and youth-facing service providers. For example, to influence member behaviors, we offer incentives for preventive care through our Healthy Rewards program. In Figure V.F.28-1, we describe our current and planned member incentives, including ***a new opportunity for completing COVID-19 vaccination***.

[redacted]

Strategies for Member Engagement

We understand that each member has unique needs with different paths to wellness, challenges, and stages of readiness to become active participants in their health. Cultural differences, values, and beliefs are key factors that inform and influence health behavior. Our care team tailors member engagement to triage identified risks through interventions ranging from health coaching to care management, depending on the member's need and readiness to engage. We use multiple methods to engage members, including calls, texts, email, mail, video conferencing, and face-to-face contact. Our patient-centered approach meets members where they are, focuses on what they prioritize in their health journey, and adapts support and engagement as members' needs change. Our diverse care team consists of key subject matter experts including CMs, Outreach Care Specialists, Medical Management Specialists, CHWs, Peer Support Specialists, and will include a Housing Specialist, EPSDT Specialist, and Employment Specialist. We align our outreach strategy to a member's level of need.

- **Culturally Competent Outreach.** We consider the member's communication needs and preferences when tailoring our engagement. We conduct culturally tailored member outreach based on detailed analysis showing high social vulnerability scores, poor health outcomes, and existing racial disparities. This outreach provides comprehensive translation services, and culturally competent staff use face-to-face outreach, two-way text messaging, and outbound calls to help resolve social risk factors and address barriers identified by members.

- **CHW Engagement.** Our CHWs will provide one-to-one support, either telephonically or face-to-face, to engage members in completing their health and social risk factor assessments and address identified needs. CHWs will connect members with needed health care services, Healthy Blue programs, and community resources.
- **Technology That Connects.** We leverage technology to promote healthy behaviors and engage members in their care, such as individualized text messages based on member need, gaps in care, utilization behavior, and their specific conditions. Members are encouraged to use our new individualized digital platform, Sydney, to receive tools and resources customized to their health history and interests, increasing the likelihood of engagement. Sydney provides members with information about their health and benefits and allows them to interact directly with our care team on the members own terms.
- [redacted]

In Table V.F.28-1, we describe some of our health and wellness engagement efforts and activities.

Table V.F.28-1. Engaging Members in Health and Wellness Activities.

Method	Description
Outbound Calls, Text, and Email Campaigns	Using data such as admission, discharge, and transfer (ADT) notifications, claims, HEDIS® reports, and prior authorizations, we identify members needing preventive care or with unmanaged chronic conditions. We send reminders for screenings through telephone alerts, email, websites, post cards, newsletters, and text campaigns. Our live calls inform members of the preventive services needed and provide education how to schedule their appointment with their PCP or other provider. Our BH teams call members hospitalized for inpatient BH care to speak with members directly and assist in planning outpatient care after discharge.
24-hour Nurse Helpline	Members have 24/7 access to our Nurse Helpline, where our trained nurses can provide education about urgent medical conditions and have access to the member's medical record to identify any gaps in care and can remind them of recommended screenings and preventive care services.
Health Education Events	Healthy Blue provides education and other supports, such as blood pressure kits, during health fairs and other community events. Using every interaction with members, we can connect members with support to schedule preventive care or other appointments to close gaps in care.
Care Management Activities	Our tiered care management activities include chronic condition management education and appointment reminders through in-person and telephonic outreach by CMs and CHWs to close care gaps. Our care management teams provide condition-specific web-based coaching, self-management supports, and education to close care gaps such as for perinatal care or EPSDT services.
Welcome Rooms	Our Welcome Rooms offer wellness and prevention classes, materials, member support, and can offer connections to community-based resources and support such as fitness and nutrition classes, maternal health education, baby showers, food distribution and other SDOH needs.
[redacted]	[redacted]

For pregnant members, there are a range of engagement strategies we use based on their needs and preferences. To encourage and support pregnant members in completing their prenatal and postpartum care, members are provided our Healthy Blue Pregnancy App. The app tracks their appointments and sends twice weekly communications (including appointment reminders and assessment surveys) tailored to the member's pregnancy stage — from prenatal through 12 weeks postpartum. The tool includes a kick counter, fetal development images, and checklists. For pregnant members with more significant needs, we engage them in ongoing low- and high-risk care management programs to connect them to prenatal and postpartum visits, provide health education and coaching, and mitigate risk factors to promote a healthy mom and baby.

To engage members in dental care, our dental partner offers multiple types of outreach. For non-utilizing members, we use data-driven outreach and send custom mailers, conduct outbound calls, and send text messages to encourage utilization. Our dental partner uses our Outreach Teledentistry program to engage non-utilizing child Medicaid members (defined as not utilizing for between 18 to 24 months) and navigate them to a Dental Home. A contracted provider outreaches to the member's parent/guardian to offer a teledentistry visit.

Using Innovative Technologies to Engage and Support Members. Healthy Blue encourages providers and members to use innovative technologies that can offer access to health resources and to promote a healthier lifestyle. Our technology supports make preventive care more readily accessible and easy to use for both members and providers. For example, in Nebraska we will be using the following technology solutions:

- [redacted]

[redacted]

Collaborating with Providers to Assure Access to Care

Healthy Blue has enhanced our provider meetings and joint operation committees to include additional clinical support/engagement for all integrated provider groups. These meetings drive interventions to help each group engage members, work collaboratively with facilities and PCPs, and assure member-level data and reports are provided, reviewed, and acted upon in a timely way. We also improved processes to shift to value-based purchasing (VBP) models and rate stabilization, adding additional specialty alternative payment models and incentives for the delivery and support of BH screenings and interventions.

We use our incentive programs to engage providers and encourage them to partner with us to improve health encourages members to adopt healthier lifestyles. Our VBPs rewards providers for improved adult and child health outcomes, increased focus on SDOH, and health equity. Our payment models and incentives target the specialty plan population by focusing on rewarding evidence-based and trauma-informed care that supports children in foster care who are at higher risk of poor health outcomes. Our VBPs offer providers the opportunity to expand their evidence-based practice offerings and for us to partner with providers to work towards a common goal of improving. Healthy Blue offers provider incentives to encourage wellness and preventive care including:

[redacted]

Influencing Healthy Lifestyles by Collaborating with Community-based Organizations

Healthy Blue has a long-standing commitment to supporting underserved communities through initiatives and partnerships that can help address complex social barriers and economic disparities to help improve health and wellbeing. We are honored to have had the opportunity to not only provide medical care to our members, but to make a positive difference in the communities we serve. Access to food and health care, maternal and child health, housing, foster care support, re-entry services and transportation play key roles in a member's whole person health and are impactful to their ability to be self-reliant. Healthy Blue's outreach efforts aim to increase utilization of our services that address these critical determinants of health and wellbeing.

Since 2019, while actively servicing and engaging our members, our community-based representatives hosted or attended more than 5,000 community partner meetings, resource fairs, diaper distributions and baby showers, and various member- and community-facing events. Each event was tailored to the various audiences and member populations and all had a primary focus on educating members and stakeholders about the coverage, services, and VAS Healthy Blue offers. In Table V.F.28-2, we provide examples of our 2022 community and stakeholder engagement activities that reached across the state through our rural and urban communities.

[redacted]

Collaboration	Description
[redacted]	[redacted]

Implementing Performance Improvement Projects Improves Health and Wellness

To encourage improved health choices and outcomes, we implement performance improvement projects (PIPs) for member populations. Our PIPs use interventions to influence member behaviors to learn how to access resources appropriately. Each of our PIPs use multi-pronged approaches to collaborate with providers and community-based supports to access resources with a focus on educating and engaging members:

- **Follow-up After Emergency Department Visit with a Behavioral Health Diagnosis.** In 2018, we developed a PIP to improve seven- and 30-day follow-up after an ED visit for SUD and mental illness with the goal of improved health outcomes and stabilization of BH conditions by linking members with appropriate and needed care. Our PIP implemented interventions such as improving current data streams through integrating our CyncHealth Information Initiative, promoting the use of our 24/7/365 BH service line to members and providers via direct mailings to members, providing materials to providers offices for members, and outreaching members who are identified as having a PIP-related ED visit to offer our care management services and follow-up appointment scheduling assistance. [redacted]
- **Plan All-Cause Readmission PIP.** This PIP addresses members who are high risk to have a readmission within 30 days of discharge from the hospital. Addressing barriers and root cause of hospital readmissions, this PIP addresses member needs and improves health outcomes as well as overall quality of health care and reduces health care costs. We focus on the multi-disciplinary needs of members who are high risk, with BH needs, and health disparities to improve the hospital readmission rate among our population. This project will cover the Plan All-Cause Readmission measure of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge Medicaid (18 to 64). [redacted]
- **Fluoride PIP.** Our Fluoride PIP will aim to improve the percentage of children ages six months through five years who received fluoride varnish application by their PCP by implementing new or enhanced interventions. Our interventions will include creating a member fluoride varnish care gap report, conducting member outreach by providing parent education or linking the member with a PCP or dental provider, and completing provider educational outreach.

No. 29

Assuring Members Receive Unrestricted Access to Family Planning Services

Healthy Blue provides timely access to family planning services for member reproductive health care and maternity needs. We do not restrict member choice and will provide family planning services and supplies coverage as outlined in SOW V.E.17. Given the rural nature of the state, many primary care providers provide family planning services, but we also have existing contracts with three free standing birth centers across the state. Prior authorization is not needed for family planning services or supplies. ***One hundred percent of our Nebraska members have access and unrestricted choice in accordance with SOW requirements to the full range of family planning services and supplies, including contraception, prenatal, delivery and postpartum care.*** Members can identify providers of family planning services and supports through the provider directory or by calling our Member Services Call Center. Sydney, our digital member engagement platform, is another means for members to exercise their unrestricted choice in identifying a family planning services provider using the Find Care tool.

Healthy Blue prioritizes the member in our delivery of services. Under no circumstances do we prohibit or restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member regarding:

- A member's health status, medical care, or treatment options, including any family planning services or supplies
- Any information the member needs to assist them in deciding among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- A member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions

We make sure that our providers are aware of Healthy Blue's commitment to provide members with unrestricted access to family planning services, treatment of certain infections or disorders, and supplies by referencing our policy in our written agreements with providers and including it in our printed and online provider handbook, including that prior authorization is not required for family planning services whether they are in-network or out-of-network. Healthy Blue members may choose a contracted or non-contracted provider for family planning services or supplies. Non-contracted family planning providers will be reimbursed at a minimum of the Nebraska Medicaid fee-for-service rate. We encourage family planning providers to communicate with the member's PCP on any form of treatment provided through CyncHealth, Nebraska's Health Information Exchange.

Supporting Providers of Family Planning Services

Healthy Blue supports providers with dedicated resources for outreach and education related to incentive models, practice transformation, and other activities to support provider performance improvement. We also educate all family planning providers on the availability and coverage of Long-Acting Reversible Contraception (LARC), as well as how to educate members. As an example, [redacted] As we review this data with providers, typically monthly, we work with them to identify any barriers or trends and offer insight into potential actions for improvement.

Improving the Quality and Availability of Family Planning Services and Supplies

Healthy Blue provides comprehensive access and unrestricted choice for family planning services and supplies, promoted by our MCH/EPSDT Coordinator. Our MCH/EPSDT Coordinator will promote and educate members on family planning services and preventive health strategies. They will work to develop and implement programs to make sure all members in need of maternal or postpartum care receive it. They will also act as a point of contact with community partners around family planning and maternal health issues. Members will be able to find family planning providers through our provider directory. Healthy Blue also works to expand family planning services and supplies options for members through partnerships with community groups, member education, and events.

Partnerships

Healthy Blue provided a $100,000 sponsorship to the Malone Center, a Black, Indigenous, and People of Color (BIPOC)-centered Doula organization in the Lincoln/Omaha area and $100,000 to the Omaha Better Birth Project, which focuses on access to health care resources and client services for low-income and teenaged mothers. We also provided $50,000 to the Omaha Black Doula Association to support maternal health and birth outcomes for underserved BIPOC families in the Omaha and surrounding areas. The Omaha Black Doula Association's mission is to decrease maternal and infant morbidity and mortality rates by providing Doula services, education, and support to underserved BIPOC families. The funding will focus on educating, training, and preparing Doulas of color to become certified and serve some of the most vulnerable community members that may not have the access or resources for such services.

Expanding Access to Family Planning Supplies

Healthy Blue has five Welcome Rooms throughout Nebraska, staffed with Healthy Blue employees who provide timely answers to individuals about their health care needs and their health plan, as well as community resources. These sites host community baby showers, diaper drives, and other events that promote neighbors serving neighbors. Educational materials on LARC, pregnancy, and our New Baby, New Life℠ brochure will also be available at our Welcome Rooms.

Healthy Blue educational Baby Showers emphasize the importance of prenatal care while informing members of resources and supports in a fun-filled environment. These events provide members an opportunity to interact in a relaxed setting, encouraging informal peer support and information sharing among pregnant members. Topics discussed may include pre/post-delivery care, healthy eating tips, and family planning, and educational materials, including information on LARC, which will be available in English and Spanish.

Healthy Blue also distributes [redacted]

No. 30

Our Approach to Providing Equitable Member Education That Improves Service Coordination

We know that health education is a crucial part of helping members achieve optimal health and wellness. Healthy Blue's goal is to improve the lives and health outcomes of Nebraskans, focus on patient-centered outreach, address health disparities and improve health equity, and align with DHHS and MLTC goals. We meet these goals through robust communication and education with members across the state, employing multiple channels to connect with them in the most efficient way according to their individual communication preferences. Our education programs reach all members, regardless of where they live, their health condition, or social needs. We achieve equitable education through proactive member outreach through Nebraska-based staff, community, and provider collaborations, using local and national resources, innovative technology solutions, data-driven digital and telephonic outreach, as well as written materials and standard communication channels.

Our approach, informed by our population health strategy, uses evidence-based practices and guidelines and starts with connecting members to the tools and resources they need to access coordinated services at the right time and in the right place, including physical health (PH), behavioral health (BH), and pharmacy services; EPSDT compliance; emergency room (ER) services; and prenatal services. We create accessible, engaging resources using health literacy principles to empower members and encourage self-management and self-sufficiency. We offer materials in print and digital formats covering topics such as health education, accessing benefits and services, value-added services (VAS), eligibility redetermination, community events, and more.

Our materials are compliant with all contractual, State, and federal requirements, MLTC-approved prior to distribution, medically accurate, and written in a culturally competent manner at a sixth-grade reading level. They are available in a variety of formats, automatically created in both English and Spanish, and can be translated into more than 230 languages and alternate formats such as large-text, audio, and braille on request. Our response to V.F.26 describes our methods for creating accessible and easy-to-understand material. Our member education plan details our approach to new member outreach, care management, and how we leverage innovative technology and tools to engage members. See Attachment V.I.30-1 for samples of our member education materials.

Innovative Member Education Materials and Strategies to Improve Service Coordination

Our comprehensive menu of written materials helps new members understand their covered services and benefits and how to access them. As long as members are enrolled in our plan, we continue to deliver materials targeted to their individual clinical and non-clinical needs based on our understanding of member demographics, self-reported needs, and diagnostic information. A selection of key written member educational material is described next.

Member Education Materials

Welcome Packet. Our new member strategies serve to orient members to our plan and improve service coordination so that they experience seamless access to services and benefits. Our MLTC-approved new member Welcome Packet is designed to connect with members in a culturally and linguistically competent way (see V.F.27 for details). The current version includes a Welcome Flier with information about accessing the member handbook and provider directory, registering for the secure member portal, and how to contact us.

Member Handbook. Primary among our member materials is our member handbook, which provides a practical and comprehensive guide about covered benefits and services. It is based on guidance from MLTC and adapted to include materials specific to our plan and programs. We designed and regularly update the handbook knowing it is an important ongoing reference for members.

Provider Directory. Our online and print provider directories are designed to assure members have convenient, accurate, information about our provider network. Provider-specific information includes their specialty, board certification, whether they are accepting new patients, group affiliation, hospital affiliation, and specialty interests. In addition to traditional demographic information, the directory includes PCPs' gender, languages spoken, Americans with Disabilities Act (ADA) accommodations and accessibility. We provide a printed copy of the provider directory to MLTC, members, and their caregivers upon request.

[redacted]

Fliers. Our Health Tips Fliers, available in print, in downloadable pdf format on our website, and posted on the Healthy Blue Blog, leverage simple language and infographics to impart important information to members. Fliers are available in English and Spanish and can be translated in to more than 230 other languages.

Videos. To accommodate members with preferences for audio and visual learning, in 2023 we will offer new members personalized onboarding videos with closed captions. Topics will include covered benefits; the QSG and member portal; selecting or changing PCPs; completing the HRS; and choosing between ER and urgent care service options.

Member Education Strategies

Welcome Rooms. Healthy Blue offers members access to five Welcome Rooms, located across Nebraska in Kearney, Scottsbluff, Lincoln, Omaha, and Norfolk, to provide members with face-to-face support. Each Welcome Room has a telehealth kiosk with translation capability, including ASL, and is equipped with rooms for private telehealth appointments or meeting with care management teams.

[redacted]

Welcome Room staff can assist members with completing job applications, viewing their eligible benefits, requesting transportation assistance, obtaining a replacement member ID card, and locating or changing their medical or Dental Home. Staff can also make referrals to care management and host baby showers, food distributions, Girl Scout/Boy Scout troop meetings, community partner meetings, support groups, CPR classes, etc.

Health Risk Screening Calls. We call newly enrolled members to welcome them to our plan and inform them that they will be asked to complete an initial HRS to help us understand their health status and needs. Later, we call members specifically to assist them in

completing their HRS. Informed by HRS results, we deliver tailored educational content. If HRS results indicate a member is eligible for case management, we can activate enrollment with their consent and will collaborate with them to complete more comprehensive assessment (Health Risk Assessment) and deliver tailored educational material.

Field-based Clinical Staff. Our local Care Managers (CMs) are available in the field to assist members with complex needs. Currently, we provide eight CMs who are focused on BH and will soon position three CMs who will focus on members with complex PH needs. Additionally, we will hire two Community Health Workers (CHWs) to be based in the field to offer face-to-face assistance to members with high-risk pregnancies and potentially complicating conditions. CHWs will track member hospitalization for BH issues. Our ***Peer Support Specialists*** focuses on the homeless population and our ***Outreach Care Specialists*** focuses on the foster care population and visits youth shelters to assist aging out foster care youth.

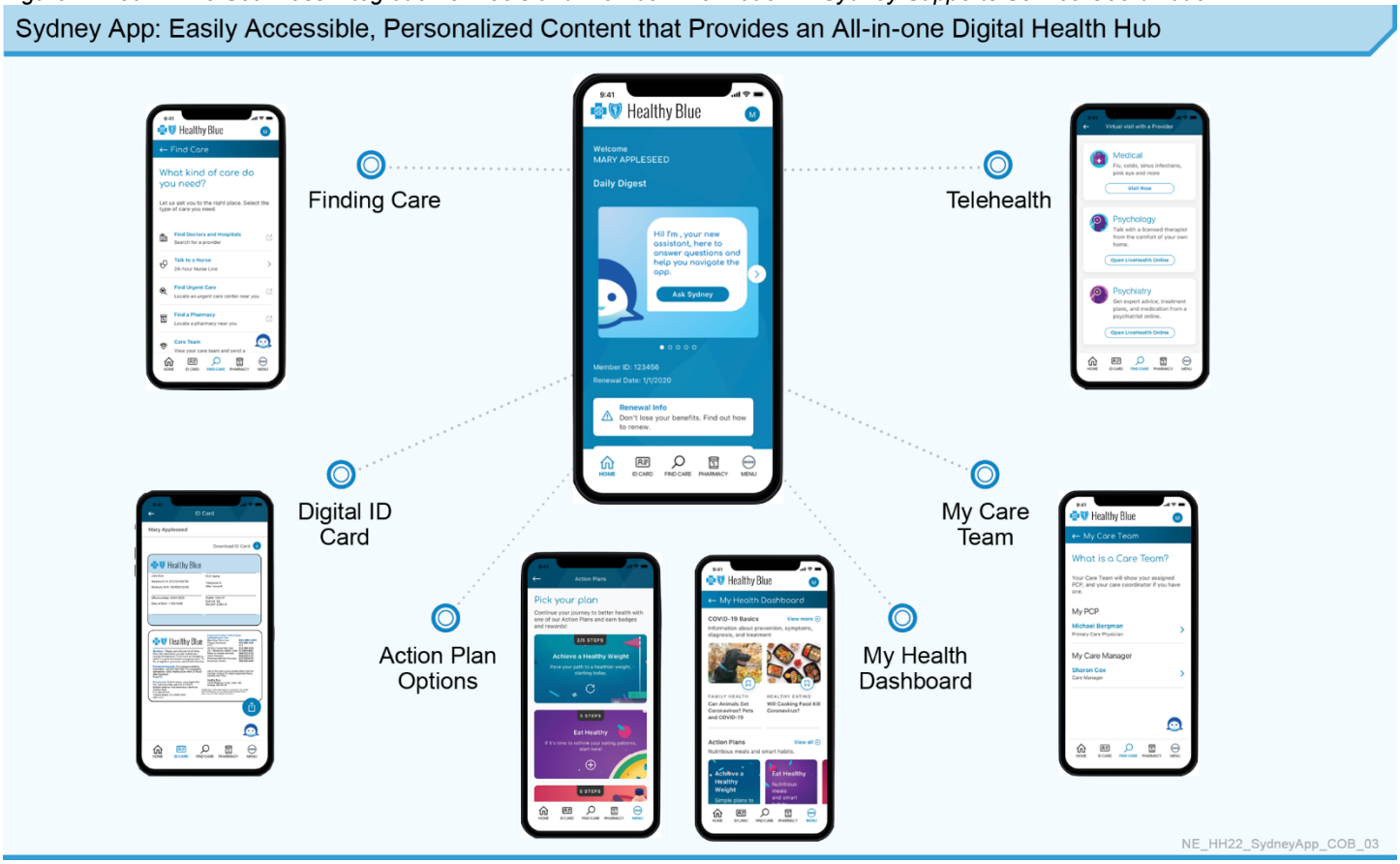
Partnerships with Community-based Organizations. We leverage our relationships with trusted CBOs to educate members during community events about our service offerings and preventive health practices that promote health equity. For example, we collaborate with CBOs and other community groups, such as Community Alliance, Centerpointe, Heartland Family Service, Lutheran Family Service, Eastern Nebraska Office on Aging, Foodbank of the Heartland, League of Human Dignity, and Project Harmony, to disseminate health education information tailored to their constituents. Twice a month, we host ***Healthy Blue Day*** at the Nebraska Urban Indian Health Coalition.

Digital Education Strategies: App, Website, Social Media, Text Campaigns

Because many members prefer to receive their educational materials through alternative (non-written) mechanisms and formats, we leverage our innovative digital solutions and technologies for education, some of which, but not all, are described next.

Sydney App (Sydney). On our mobile app, Sydney, and secure member portal, we leverage advanced analytics to provide resources based on a member's preferences and needs (see Figure V.F.30-1). Sydney uses AI data science and a member's communication preferences to deliver a personalized digital experience. In one simple, digital solution, Sydney offers members seamless access to enrollment communications. clear benefit details, provider directory, HRS, easy-to-use care finder tools, and health improvement programs. Members engaged in care management can use Sydney to message their assigned Care Manager, update their health status, or arrange for a more interactive contact by phone. [redacted]

Figure V.F.30-1. The Seamless Integration of Tools and Member Information in Sydney Supports Service Coordination.



Additionally, using Sydney, members can access ***My Health Dashboard***, a centralized hub that personalizes messages based on claims and condition-based data and self-reported interests. The dashboard displays information about how members can make better health decisions, take advantage of relevant benefits and programs, and incentivizes healthy practices through achievement of badges

for meeting health goals and completing interactive action plans, such as Achieve a Healthy Weight; Eat Healthy; Get Active; Increase Energy; Reduce Stress; and Sleep Better.

[redacted]

Website. Our member website offers numerous resources for members that improve service coordination, including:

- [redacted]
- **Member Handbook.** Comprehensive resource informing members about benefits, services, and more.
- **Health and Wellness Page.** Provides quick, easy access to information, interactive tools, and tips to help members manage their health care, including our Health Tips Fliers.
- **Health A to Z.** Provides information and answers on many health topics, a symptom checker, and interactive tools.
- **Useful Apps.** Offers a number of free, downloadable apps to manage health care such as nutrition, medication management, tracking blood sugar, and more.
- **Calendar of Community Events.** Will offer a list of events for members and the general public with a primary focus on the benefits, services, health promotion, enhanced services, and Healthy Rewards. To be implemented.
- **Newsletter/Blog.** We supplement our ongoing communications with a member newsletter blog (blog), issued at least two times per year, which contains key information about managing chronic illness, preventive care, tobacco cessation, HIV/AIDS testing for pregnant women, BH, and tips to improve overall health and wellness.

Text Campaigns. We design and deploy innovative text campaigns to improve service coordination, including:

- Our Low-intensity Emergency Room (LIER) pilot program, initiated in Nebraska in Q4 2021, is intended to help decrease potentially preventable ER usage and increase member enrollment in case management. We use predictive modeling to identify members at risk for making avoidable and unavoidable ER visits. Based on their level of risk, we send these members texts over six months and conduct educational outreach, case management, and care coordination.
- To close HEDIS® care gaps, we deploy text campaigns to remind members to schedule their wellness checkups or complete their needed immunizations. ***In July through December 2021, we sent more than [redacted] text messages to members about care.*** In that same timeframe, [redacted] members clicked on phone numbers to inquire about Healthy Blue Member Services or transportation.
- For members with BH-related needs, including substance use disorders (SUD), we identify members for educational outreach via text based on their ER utilization. Our messages provide members with care alternatives and encourage them to visit a provider for follow-up care if mental health or substance use is a known visit reason.
- Based on prior authorization data, we will seek MLTC-approval to initiate a text campaign to send messages to members who were hospitalized for a BH need. The messages will encourage members to complete a follow-up visit with their BH provider within seven days of discharge.

Healthy Rewards Platform. Our newly upgraded Healthy Rewards online incentive platform for members includes rewards tracking, physical activity and well-being promotion, and other personalized tools. Members can access the Healthy Rewards platform via single sign-on from our secure member portal or call for phone-based support. Once enrolled in the Healthy Rewards program, members will receive health education information and incentive opportunities tailored to their gender, age, health risks, and other demographics. [redacted]

Population-specific Social Media. We invest in social media to disseminate health education content. For example, we posted messages on our Healthy Blue Facebook and Instagram pages related to pre-teen and teen HPV immunizations and COVID-19 vaccinations. The digital campaign focused on members with specific vaccine hesitancy through segmented messages addressing possible concerns and providing additional information, see Attachment V.I.30-1d. In Q1 2022, we reached nearly 700,000 people with our Healthy Blue social media posts, resulting in more than 10,000 clicks on our shared links.

[redacted]

Educational Materials and Strategies Support Seamless Service Coordination

In addition to the materials and strategies described previously that support service coordination, we highlight examples next.

PH, BH, Dental, and Rx Integration

Our member education material and strategies connect members to the tools and resources they need to access coordinated services, including PH, BH, and pharmacy services. For example,

- Healthy Blue leaders, Chief Executive Officer (CEO) Dr. Rob Rhodes and Behavioral Health Clinical Director Dr. Martin Wetzel, appeared on local television show, “Mom’s Everyday,” to discuss the Healthy Blue plan and health topics such as COVID-19 vaccination and children’s mental health. They used MLTC-approved scripts to reach community members including pregnant women, parents and guardians, providers, and the Medicaid-eligible population in general.

- Healthy Blue will hire CHWs as field-based clinical staff to support members throughout the state. As part of their responsibilities, CHWs will track member hospitalization for BH issues. We will use prior authorization data to send members text messages related to their BH needs, encouraging them to complete a follow-up visit with their BH provider.
- Our ***Medication Therapy Management*** (MTM) program is in place to optimize therapeutic outcomes for Medicaid members by assisting members with sub-optimal use of medications (for example, over- or under-utilization) and educating them on understanding their prescriptions and adherence to medication regimens.
- We are working with pharmacies to provide ***HealthTags*** — reminders for actionable health care information such as a reminder to complete an A1c test for diabetic members — printed directly on members' prescription bags.

EPSDT Compliance

We recognize the importance of making families aware of the importance of EPSDT services. We combine culturally competent innovative outreach tactics, traditional member education strategies, and targeted initiatives and collaborations to promote understanding of EPSDT services. Following initial outreach and education, we continue to educate families and caregivers about appointments due, the importance of closing care gaps, and the help available to complete preventive care and treatment through automated outreach, calls, texting, and mailing campaigns; social media, including Facebook and Twitter; and community events. As part of our approach to comprehensive and coordinated care, CMs and Care Coordinators reinforce education about EPSDT services during contacts with members and their families and provide personalized help coordinating access to EPSDT services. Some additional efforts we make include:

- To encourage child and adolescent members in keeping up to date with EPSDT services, we mail each member an EPSDT reminder postcard to wish them happy birthday. The postcard lists the recommended services, including well-child visits and immunizations that they should obtain in the upcoming year.
- Providers are an important conduit for member education. To support providers in improving service coordination, we will hire a Maternal Child Health (MCH) EPSDT Coordinator and EPSDT Specialist to educate providers on conducting screenings and closing care gaps. We also offer providers an EPSDT Toolkit, which includes information on EPSDT requirements, information on billing and coding, and information on how to engage and educate their patients on the importance of the timeliness of EPSDT services.

Appropriate ER Utilization

With effective service coordination that promotes preventive care, we assist members in avoiding unnecessary ER visits. Some examples of our member education efforts to this end include:

- Our (LIER) model, intended to divert members from unnecessary use of the ER, will send members text messages throughout a six-month cycle of the program. Messages are tailored to the level of risk members have of unnecessarily using.
- On our member website, we host a dedicated page called ***Getting Care 24/7***. Content on this page describes differences between urgent care and ER and informs members how and when they should use these different service sites.

Prenatal Services

From the moment we know a member is pregnant, we deliver tailored educational content on pre- and postpartum services for a healthy pregnancy and healthy baby in various formats (texts and written materials) to those women, including the following.

- New Baby, New Life℠ is a proactive care management program for mothers and their newborns. As part of our New Baby, New Life program, members can access our ***My Advocate***™ tool, which delivers maternal health education by smart phone app, website, or IVA; tracks prenatal appointments; and sends twice-weekly communications, including appointment reminders and assessment surveys tailored to the members' stage of pregnancy.
- Healthy Blue offers ***baby showers*** in all five of our Welcome Rooms and with our CBOs partners. During the showers, we distribute diapers to new mothers and provide education on topics such as safe sleep, and sudden infant death syndrome prevention training.
- [redacted]

Social Media, Mobile Technology, and Other Tools

In addition to the numerous resources available on our website and described earlier in this section, we offer social media, mobile technology, and other tools to improve service coordination, such as:

- Our ***Sydney mobile app*** sends members reminders for screenings, medication refills, and checkups. Additionally, the app notifies families of their child's gaps in care. Via the app, members can quickly access their Care team and send messages requesting support.
- We implement numerous ***text campaigns*** educate members on their health needs, help them connect with their PCPs, and close gaps in care. Campaigns include wellness checkups, immunizations, chronic conditions, as well as Healthy Blue's LIER program to educate members on when to go to the ER versus urgent care to decrease inappropriate ER utilization.
- Using a data-driven approach, we disseminate health messages through ***digital and social media*** to members that most need the information. For example, Healthy Blue developed social media and digital display ads focusing on COVID-19 vaccine hesitancy and then identified audiences aligned to each concern. The messages focused on community and equitable access to the vaccine (focused on urban areas) or on the idea that vaccines were the way we could move beyond COVID-19 and get back to our livelihoods (focused on rural areas). In addition to geotargeting in Nebraska, we also focused the campaign on members with a high Social Vulnerability Index (SVI), meaning they may be more vulnerable to severe illness or hardship should they contract COVID-19. By segmenting and focusing our messaging, we met or exceeded benchmarks for click-through rates and reach in most cases.

Partnerships with Community-based Organizations

We partner with several CBOs to provide member education that improves service coordination, including:

- **Intercultural Senior Center (ISC).** The ISC supports seniors, many of whom are refugees, facing barriers to care and improves their quality of life through nutrition education. Healthy Blue collaborates twice a month with ISC, Nebraska Methodist College Mobile Clinics, and OneWorld to provide A1C testing, BP and glucose monitoring, lead and mammogram screening, as well as

health presentations on various rotating topics, including Parkinson's disease, minority health awareness, vision, breast cancer screenings, COVID-19 vaccines, tips for healthy living, foot care, diabetes screening, and nutrition education.

- **Norfolk Family Coalition (NFC) and Xanat Naranjo.** We collaborated with the NFC and Xanat Naranjo, an independent lactation consultation, to host a baby shower in the Norfolk Welcome Room to provide information to nine Healthy Blue members about their benefits, VAS, Healthy Rewards, breast feeding tips, and making connections for follow-up support. Three member attendees requested and received follow-up meetings with Healthy Blue staff.
- [redacted]

We offer grant funding to the following CBO partners to bolster service coordination for pregnant women:

- ***Omaha Black Doula Association***, which offers certification training to new Black, Indigenous, and People of Color (BIPOC) doulas, scholarships for BIPOC mothers for labor/postpartum doula support, and childbirth educator certification for doulas.
- ***Omaha Better Birth Project***, which offers childbirth education classes, birth doula grants, a diaper program, and community-based prenatal and postpartum support groups.
- ***Malone Center***, which offers birthing classes, breastfeeding classes, doulas, etc. for BIPOC families. In collaboration with Healthy Blue, the Malone has hosted successful community-based events such as presentations and gatherings to educate the community on the fight to overcome HIV and AIDS. In addition to spreading awareness and materials that destigmatize mental and sexual health topics. Healthy Blue supports Malone Maternal Wellness Doula program to serve the state BIPOC population. The funds support Malone Center's Maternal Wellness team and enabled the team to expand outreach in Lincoln and Omaha.

No. 31

Member Grievance and Appeals Process

The Healthy Blue Grievance System, which manages processes for member grievances, appeals, and State Fair Hearings, complies with federal and State regulations and operates based on the definitions and requirements in SOW.V.H. Our Grievance and Appeals team maintains and implements a patient-centered approach to resolving member grievances and appeals and helps assure that members have access to expedited review processes, external reviews, and the State Fair Hearing system. We maintain and update our written policies and procedures for our Grievance System, reviewing them at least annually or on as an-needed basis. We complete all our grievance processes and activities internally and do not subcontract out any of these services. Our team is available to members whenever they have questions or need support filing a grievance or appeal. Our Member Services Representatives (MSRs) can help members file a grievance or appeal and can provide updates on the status. We do not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who wants to file an appeal.

We make sure processes are fair, objective, understandable, easy to use, and clearly defined for members. We provide ongoing training to our staff, providers, and subcontractors to assure our process meet members' needs. Healthy Blue interacts with members in a courteous, culturally competent, and professional manner, and makes every effort to resolve any issues through a well-defined process that supports the member every step of the way. We automated our process to be sure we acknowledge a grievance in writing before the ten-day requirement. We recognize and appreciate the importance of a patient-centered, responsive Grievance System that includes processes for prompt resolution of grievances and appeals. We provide a system to identify and resolve grievances and appeals quickly and one that treats all members equitably and effectively in a culturally and linguistically appropriate manner. Healthy Blue also provides support if members need help due to a hearing or vision impairment, if they need translation services, or help filling out the forms. Interpreter services are available for any language a member may need, as well as teletypewriter/telecommunications devices for members who are deaf.

Members, their designated representative, or providers authorized by members, can submit a grievance in a variety of ways. These include: through our Sydney app, our member portal, and/or by contacting Member Services by phone, or in writing by mail, email, or fax. Healthy Blue accepts a grievance at any time.

We notify members in writing of the disposition of all grievances within 90 calendar days of receipt of the grievance, and most often within 30 calendar days. If a complaint is about the denial of an expedited appeal, we send the member written acknowledgement within 72 hours of receiving it. We review complaints about the denial of a standard appeal and send the member written acknowledgement within 10 calendar days of receiving the complaint.

If a member disagrees with our decision about care or services requested, they can file an appeal. Members have 60 calendar days from the receipt of the Notice of Adverse Benefit Determination to file an appeal. The appeal can be made by phone or in writing. Healthy Blue acknowledges receipt of the appeal in writing in within 10 calendar days of receiving it. Appeals are resolved within 30 calendar days from when we received the appeal. [redacted] If the appeal review needs to be expedited because of a member's immediate need for health services, we provide written acknowledgement of the request for an expedited appeal within 72 hours of receiving it. Our process for processing member grievances and appeals in a timely manner is outlined in Figure V.H.31-1 and Figure V.H.31-2.

Figure V.H.31-1. Handling Grievances in a Timely Manner.

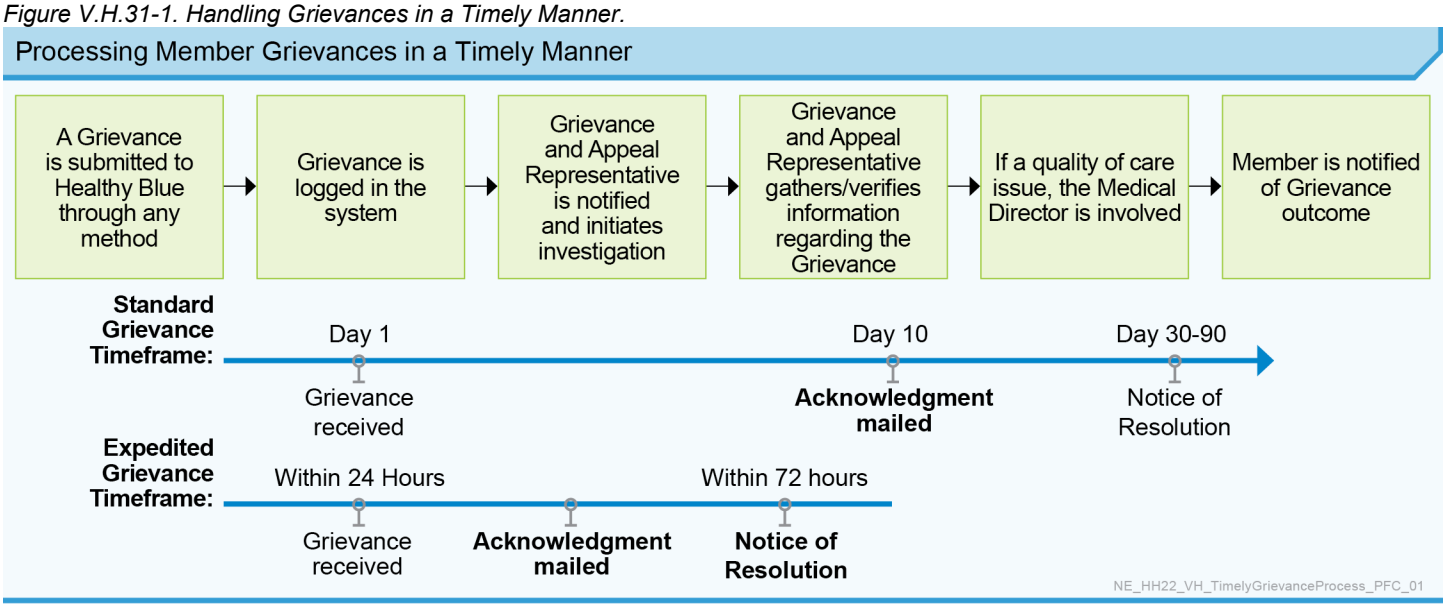
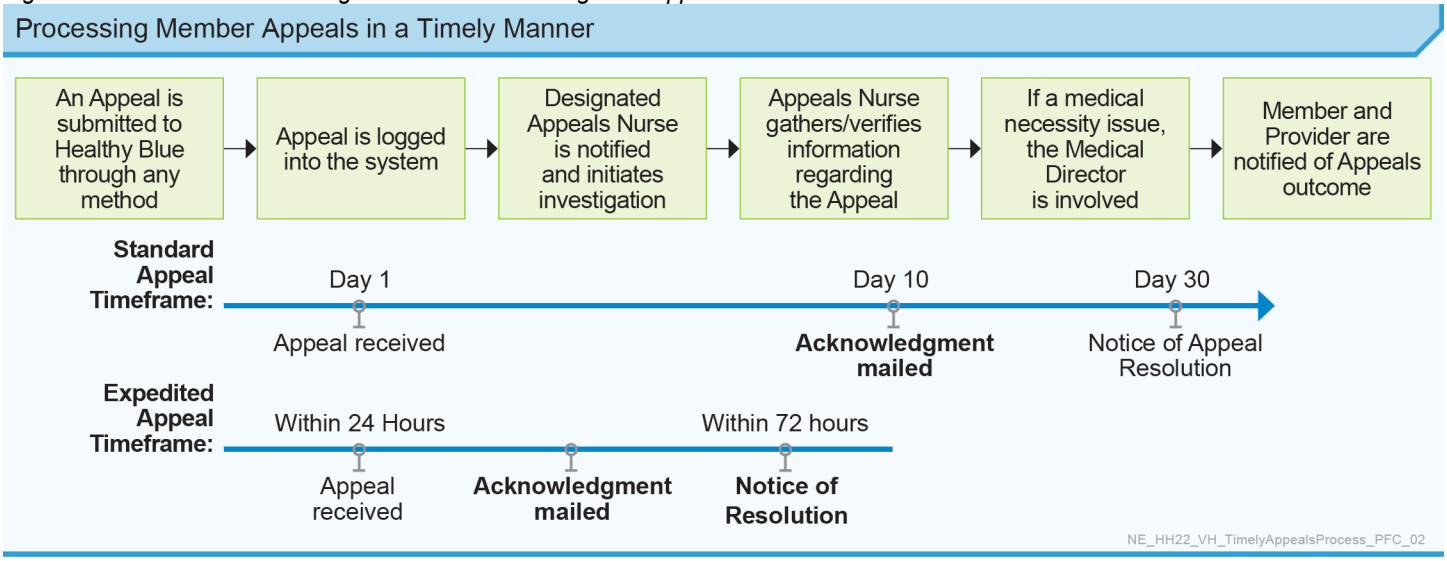


Figure V.H.31-2. Communicating with Members Through the Appeals Process.



Heritage Health performance metrics require 95% compliance with acknowledgement letter and resolution letter timeframes for member grievances and member appeals. [redacted]

Ensuring Expertise in Decision-making

When we identify a grievance related to quality of care, we promptly complete a full investigation to assure expedited processes are used when appropriate. We maintain a policy and procedure to ensure that every grievance involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise, and escalated to our Medical Director as needed, to ensure the grievance is properly handled. The Grievance and Appeals Representative classifies the issue to appropriately coordinate the investigation process through additional levels of review as applicable. We assure that a licensed clinician, Medical Director, and Review Nurse conducts a full investigation of clinical issues.

When appropriate, we refer cases to internal and/or external physicians through our Quality of Care Subcommittee and our Peer Review Committee. When appropriate, we refer cases to our Credentialing department, including the Credentialing Committee comprised of both internal and external physicians. The Grievance and Appeals Representative and Clinicians work collaboratively to make sure all applicable information is available.

No individual who completes the review and makes decisions for grievances and appeals will have been involved in previous levels of review or decision-making, or in a subordinate role of previous decision-maker. The Grievance System staff will confirm that any clinician making any final decisions is not the same Nebraska licensed Physician who participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in the prior decision. All previously considered information, in addition to any new information provided, will be considered by the clinician during the review. A clinician will resolve the expedited request within 72 hours of receipt unless this time frame is extended under any of the circumstances described in SOW V.H.5. For grievances and appeals involving clinical issues or denials based on medical necessity, a service that is experimental or investigational, or a request for an expedited resolution, the person making the decision will have clinical expertise. All grievance or appeals related to medical quality of care issues are submitted to a Medical Director.

As part of Healthy Blue's Compliance team, our Grievance System Manager, Julie Godbout, receives, triages, and tracks all member and provider complaints, grievances, appeals through resolution, as well as State Fair Hearing requests and all issues reported to Healthy Blue from MLTC. She assures issues are addressed, grievance and appeal timelines are met, and all documentation is available as required in SOW V.D.2 and V.H.

Ensuring Expedited Processes

Healthy Blue maintains policies and procedures to expedited processes are available for grievances and appeals as detailed in SOW V.H., where we determine (or the requesting provider indicates that) taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. A member, a provider, or an Authorized Representative may file an expedited grievance or appeal either orally or in writing with no additional follow-up from the member required. No punitive action is taken against a provider who requests an expedited resolution or supports a member's appeal.

We use a systematic approach to resolving member grievances and appeals and make sure members, or their designated representative, have easy access to our expedited review processes to facilitate quick resolution and prompt access to time-sensitive treatment. The member or designated representative, including a provider or attorney, can request an expedited grievance or appeal if the turnaround time for a standard appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Expedited appeals may be filed orally or in writing via fax, or email, and we do not require oral appeal requests to be followed by written requests in such cases.

Healthy Blue may also determine taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. For medical care or treatment in which the application of the

period for making a standard determination would be detrimental to the member, our Grievance and Appeals Representative immediately notifies the member by telephone, if possible, of the determination. We use clinical judgment in reviewing all requests for an expedited appeal.

We acknowledge the grievance or appeal verbally and provide a member notice, as quickly as their health condition requires, but no later than 72 hours from the day we receive the request for an expedited resolution. We provide oral notice of the resolution of an expedited appeal to the member, provider, or designated representative within 72 hours.

When Healthy Blue receives a grievance requesting expedited resolution, the grievance is sent to a clinical nurse to review and determine if the grievance meets criteria for expedited resolution. If upon receipt of a standard grievance, we are unsure if the grievance should be reviewed for expedited resolution, a non-clinical representative will send the grievance to a nurse to review for expedited criteria. If taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health or the ability to attain, maintain or regain maximum function, the request will be expedited.

Leveraging Data to Improve Operational Performance

Our members are an important source of information regarding our performance. If they are not satisfied with their care, we want to know about it. In compliance with all the requirements in SOW H, our dedicated Grievance System within our Core Service Platform (CSP) will store all data elements needed for our grievance and appeals processes. Our system will allow us to track the receipt and resolution of grievances and appeals and submit the required reports and trends to MLTC per SOW V.H.11.

We have built visualization tools and metrics dashboards for grievance analytics. This data is categorized using reasons for grievances, sources of the grievance or appeal, and timelines of response and resolution. The analytics tools are updated daily where appropriate to assure we have a current view into the inventory. Further analysis using grievances and appeals data includes monthly turnaround reporting, weekly and monthly volume trends, and deep-dive analysis to identify root cause.

We will link our Grievance System to our quality improvement (QI) plan and program evaluation that includes an analysis of grievances and appeals to inform continuous QI activities. We will track and trend grievance data by type and appeal data by service type. We will review grievance trends at the Quality Assessment and Performance Improvement Committee (QAPIC) to identify trends and discuss proactive solutions to improve processes and reduce the overall volume of grievances. Grievances related to quality of care will be fully investigated and referred to our Credentialing department and Clinical Advisory Committee, as appropriate. If a member filing a grievance is determined to have a care management issue or an assigned Care Manager, the Care Management team will be notified and engaged as needed to resolve the member's issue.

We will review grievance and appeal data by categories, such as type of care and volume. A dedicated team of risk analysts within the grievance and appeals team will continuously mine data and monitor these trends weekly to be proactive in addressing members' concerns and contribute to programmatic continuous QI efforts.

These reports and analyses will also be presented to the QAPIC on a bi-annual basis to discuss solutions to facilitate access to clinically necessary care, reduce any unnecessary burden on providers, and reduce the overall volume of appeals.

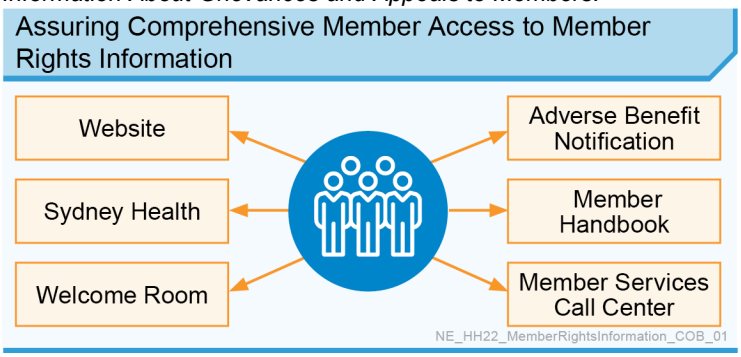
[redacted]

No. 32

Assuring Members Receive Information on Grievance, Appeal, and State Fair Hearings

Healthy Blue's goal is to improve the lives and health outcomes of vulnerable Nebraskans, focus on member-centric outreach, health equity, and align with the State's goals. We will achieve this through robust communication and education, employing multiple channels to connect with members efficiently and according to their communication preferences.

Figure V.H.32-1. Healthy Blue Uses Every Opportunity to Convey Information About Grievances and Appeals to Members.



We view every encounter with members, whether via mail, email, phone, digital, printed materials, or virtual or in-person interactions as an opportunity to educate members about their services and their rights. The most crucial time to encourage engagement is when a member first enrolls. Our goal is to establish rapport and confidence with members to assure a level of comfort and ease with us, not just as their MCO, but as a trusted resource for their health and well-being. It is also part of our commitment to excellence to assure members are fully informed and understand all their rights and responsibilities under the Grievance System. Methods for assuring comprehensive member access are shown in Figure V.H.32-1.

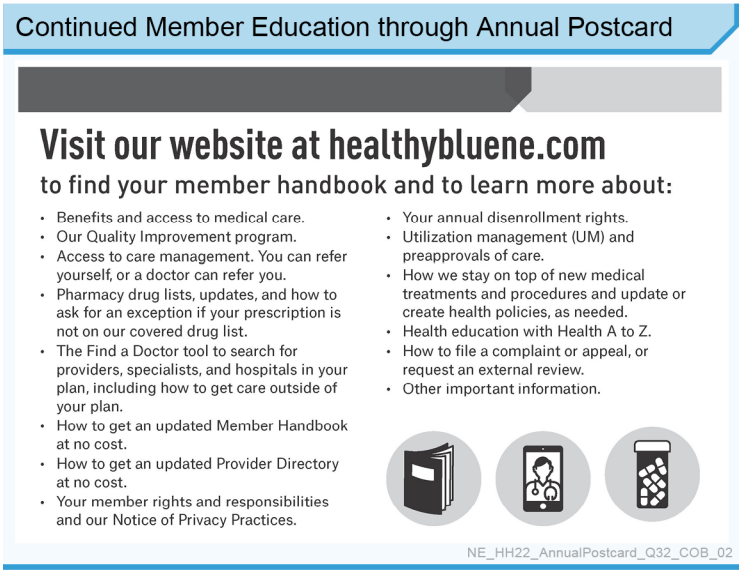
Member Services Call Center. Our Member Services department is an important point of contact and resource for members. We educate our members on how, when, and why to contact our trained, Nebraska-based Member Services Representatives (MSR). We use multiple channels and methods to make sure members know Member Services is a valuable resource to promote access to benefits and services, including our Grievance System. Our MSRs inform members how to file a grievance or appeal and receive specific training regarding member rights and responsibilities regarding grievances, appeals, and State Fair Hearings.

Member Materials. Primary among the materials we use to inform members about our Grievance System is the member handbook, which provides a thorough description of the processes and requirements for grievances, appeals, and State Fair Hearings. Our member handbook, written at a sixth grade reading level and in a culturally appropriate manner, provides comprehensive information about Member Services' role in assisting members with all their health care needs, such as providing information about covered benefits and services, and filing a grievance or appeal. The handbook also informs members that we can help them file grievances in their language and that we will not take any adverse action against them for filing a grievance or appeal. This is also true for a provider who supports a member's grievance or appeal. In addition, written guidance on process and time frames to file a grievance or appeal is included in all Notices of Adverse Benefit Determination a member may receive.

Member Outreach. In-person and telephone interactions with members offer additional opportunities to inform members of their rights and avenues of recourse. On-site staff at our Healthy Blue Welcome Rooms, with five locations throughout the state, are available to answer questions and provide support in filing a grievance or appeal. At our quarterly Member Advisory Committee meetings, attended by members, community agencies, and providers, we share grievance trends, review how to file a grievance, and walk-through member rights. We also remind members about the availability of the member handbook on the member website through an Annual Postcard (Figure V.H.32-2) informing them about how they can obtain vital information about the health plan, their benefits, and how to file a complaint or appeal. ***In 2021, we mailed our Annual Postcard reminder to households with multiple and single members, totaling 62,614 postcards.***

By fourth quarter of 2022, Healthy Blue will educate members about the Grievance System through our new member orientations, to be available virtually or in our Welcome Rooms. Additionally, we will use educational and outreach events, in-person education with our Community Health Workers and Marketing and Community Outreach Representatives, as opportunities to inform members about the function of Member Services and the resources available to support them in filing a grievance or appeal. Healthy Blue will also be developing a text messaging campaign educating our members about our Grievance System and how to access it.

Figure V.H.32-2. Our Comprehensive Member Education Campaign Includes an Annual Postcard with Critical Information for Members.



[redacted]

[redacted]

Our Website, Secure Member Portal, and Mobile App. Our public member website, secure member portal, and mobile app also function as excellent resources to educate our members about the Grievance System. Our public site, easily accessible to members and the community, includes information about grievances, appeals, and State Fair Hearings, as well as fillable, downloadable forms.

Assuring Materials Are in the Member's Primary Language

Healthy Blue makes all written materials, including, grievance and appeal notices, and denial and termination notices in English and Spanish, and will add any other non-English languages identified by MLTC for the duration of the contract. A written translation in any language for any grievance and appeals policies and procedures and notices will also be provided to any member upon request. If a member needs help because of a hearing or vision impairment or needs translation services or help filling out the forms, Healthy Blue provides the support needed. To support members who may need assistance with health plan communications, such as members who are blind or have limited vision, are deaf or hard of hearing, or have developmental disabilities, difficulties communicating or limited reading proficiency, we offer a wide variety of supports, including providing materials in auditory translation, braille, and large print format, in both English and more than 230 non-English languages, upon request and at no cost to the member.

Assuring Assistance Is Provided to Help Members File Appeals

All Healthy Blue employees who interact with members receive trainings about how to inform and educate members about their rights to file a grievance or appeal, including their right to a State Fair Hearing. We train our employees to inform members of these rights whenever a member, or designated representative, express dissatisfaction with their experience. Members receive assistance when completing grievance or appeal forms, and all other procedural steps, which include providing the member with all documents used in the decision process and using auxiliary aides and services upon request.

Face-to-face support with the grievance or appeal filing process is also available at our Healthy Blue Welcome Rooms, located in Kearney, Lincoln, Omaha, Norfolk, and Scottsbluff. The Welcome Room staff is part of the Member Services team, all trained to best meet the needs of our members. Healthy Blue has a “no wrong door” policy to assure that members receive the support they need.

We work directly with members and make weekly attempts to reach members when they have submitted a grievance to Healthy Blue. We reach out to providers and pharmacies if we do not have a correct phone number for the member. If we become aware of an additional benefit a member may need while assisting them with a grievance, we discuss alternative departments within the plan who may help the member (for example, behavioral health or case management). MSRs assist the member with any forms that need to be completed and any other information as it relates to the grievance process, which includes translation of our member materials or any other assistance. We focus on responding to members courteously and professionally and resolve issues through a well-defined and documented process that supports the member at every step. As a core element of our own cultural competency program, we make sure members and their caregivers have access to culturally and linguistically responsive services to support their involvement in the Grievance System.

No. 33

Provider Network Outreach Approach and Recruitment Strategy

Healthy Blue has built and maintained a robust and sophisticated provider network including high-quality PCPs, behavioral health (BH) providers, specialty providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), urgent care facilities, pharmacies, hospitals, Indian health service providers, Non-Emergency Medical Transportation (NEMT), allied health care professionals, and ancillary providers since 2017. Since then, we have proudly developed meaningful relationships with over 25,000 Medicaid providers in more than 225 subspecialties statewide, transitioning from payor to partner — working together to address local health challenges and assure timely and appropriate access to care for members. Figure V.I.33-1 highlights our current provider network. We will remain committed to our ***Provider Promise*** as we continue growing our provider network in diversity and geography. ***The Healthy Blue Network Development Work Plan for 2022 is presented in Attachment V.I.33-1.***

[redacted]

In Q1 2022, ***our provider network fully met geographic standards for: PCPs in urban, rural, and frontier counties; high-volume specialists (cardiology, neurology, oncology/hematology, orthopedics, OB-GYN), BH inpatient and residential services; BH outpatient and assessment treatment in urban and rural areas; and hospitals in urban and rural areas***.

Healthy Blue's Network Development Plan (Plan) Guides Outreach and Recruitment

Our plan guides our expert team in developing a strategy for the upcoming year, improving and enhancing our provider network to support the changing needs of our members. The plan is based on a deep understanding of our member demographics and anticipated needs, point-in-time network adequacy assessments including geographic and appointment availability access, and member and provider satisfaction indicators. We also model population growth trends, member health needs, and provider availability shifts (such as provider retirement, relocation out-of-state, desire to discontinue serving Medicaid members, and panel closures). Healthy Blue's data-driven approach leveraging qualitative and quantitative data sources to analyze current access and develop comprehensive predictive models to project changes in network availability compared to anticipated member needs. We review provider network outreach and recruitment activities from the current year for successes and lessons learned for the coming year. We combine our assessments of past, present, and anticipated member needs with our deep knowledge of our provider network to develop priority areas for network development activities in the coming year. [redacted]

Based on our analyses and Network Management team's assessments (detailed later in this section), our 2022 Network Development Plan prioritizes recruitment efforts for the following provider types to sustain and enhance access to care for our member population:

[redacted]

Key Strategies for Outreach and Recruitment. We use a variety of methods to identify providers for recruitment to our network. We solicit input from members, advocates, community-based organizations, in-network providers, and provider associations. We also leverage access trade sites, competitor directories, and relevant Medicaid provider lists to identify new recruitment targets not yet

enrolled in Medicaid. We analyze single-case agreements (SCAs) to identify non-network providers we could add to our network. Our Utilization Management (UM) team authorizes the non-network provider, and our Network Management team creates the SCA and identifies the opportunity to offer the provider a contract. We also look at geographic areas with identified and anticipated access challenges, prioritizing provider identification, outreach, and recruitment. ***We are implementing digital provider enrollment that reduces the required paperwork.*** Contract Managers are assigned to providers to help them navigate the contracting process, including enrollment as Medicaid providers with MLTC, before adding them to our network.

[redacted]

Meeting with Provider Associations to Nurture Relationships and Identify Needs. Successful provider recruitment requires relationships and bidirectional communication. We meet with provider associations to identify any issues related to credentialing, roster load, claims configuration, and payment. In 2021, we met with the Nebraska Association of Behavioral Health Organizations; the Nebraska Physical Therapy, Occupational Therapy, and Speech-Language-Hearing associations; the Nebraska Association of Transportation Providers; Health Center Association of Nebraska (representing FQHCs); Nebraska Medical Association; The Lancaster County Medical Society; Nebraska Healthcare Association (representing nursing facilities); and the Nebraska Psychological Association. Based on feedback from the therapy associations, we changed our process for adding new providers to existing groups. After listening to the concerns expressed by the Psychological Association related to the administrative burden faced when conducting peer to peer reviews, our UM team developed a slide presentation for the association to clarify documentation expectations. We plan to meet with provider associations more regularly beginning third quarter of 2022.

HEALTH EQUITY

Engaging Tribal Partners to Assure We Are Meeting Tribal Needs. We recognize that our Tribal population faces disproportionate challenges related to access to care. Our Tribal Network Liaison, Gelisha Jeffers, part of our Provider Experience team, meets monthly with each tribe to review specific Tribal needs, provide support, resources, and advocacy, and serves as the point person for any requests. The Tribal Network Liaison participates in all monthly State Tribal meetings, in-person, virtually, or by phone as appropriate in response to the pandemic. Healthy Blue CEO Dr. Rhodes has committed that he or one of our executive leaders will be attending these meetings quarterly to help us understand and address Tribal concerns and promote communication. Additionally, we will designate a staff member as a dedicated Tribal Member Advocate in 2022. We treat all Tribal providers as network providers.**Continually Seeking to Recruit Providers, Especially in Rural and Frontier Areas.** We accept all eligible providers into our network, giving us a broad and diverse network. In many cases, we are contracting with all Nebraska Medicaid providers in our service area, so we look outside of our current service area and out of state to expand our network. We also look for new providers in areas that tend to struggle with access issues. We are currently looking for PCPs who are registered with Nebraska Medicaid in frontier and rural counties and verifying if they are contracted with Healthy Blue. If the enrolled PCPs are not in our network, we engage and recruit them.

In some areas, there are no qualified providers, so we must employ creative solutions and collaboration. In early 2022, we established a ***Rural Health Strategy Workgroup*** to assess and make specific recommendations to supplement our financial and administrative efforts, to address access to care in rural and frontier counties. Meeting monthly and co-chaired by the Health Equity Director, the group is comprised of Healthy Blue employees who interact with members and the community, and representatives from Provider Experience, Quality Management, Operations, and Clinical teams.

We also collaborate with Nebraska's Division of BH on several program improvements, and see an opportunity to work with DHHS, community-based organizations, and other MCOs to identify innovative ways we can collaborate to address provider workforce limitations. For example, we partnered with CHI Health and two MCOs to collectively commit $1 million to a partnership with Pathways Community HUB Institute that will help at-risk moms and moms-to-be deliver and raise healthy babies. Additionally, we partnered with the Behavioral Healthcare Education Center of Nebraska (BHECN) to sponsor two conferences on the use of Collaborative Care to leverage psychiatric services in the PCP setting.

Leveraging Telehealth Services to Enhance Network Access. Healthy Blue is expanding telehealth, especially for those members who live in rural or frontier areas with provider shortages, or who have special or emergent needs. For example, we are promoting the use of telehealth BH services, as it is especially difficult to recruit providers of higher levels of BH care services. Detailed in V.E.21, we have employed LiveHealth Online video visits, Digital Solutions (telehealth) kiosks, and Telehealth Kits, and we will be implementing Telehealth OS platform for providers, TytoCare Home examination kits, Teledentistry, ConferMED consultation with specialists, Virtual Retinal Eye Exams, Brave Health BH digital care, StationMD secure video-conferencing, and Virtual Primary Care (member driven virtual primary, urgent and behavioral health care app available via mobile and web). Additionally, [redacted]

Libery Dental and ModivCare. ***We leverage our pharmacy affiliate, IngenioRx, our dental partner, Liberty Dental, and our transportation partner, ModivCare, to identify and recruit specialized providers.*** These partners have experience successfully setting up new provider networks in multiple states; for example, IngenioRx has established pharmacy networks in 16 states. Our partners are well-positioned to build and maintain a statewide network to deliver all covered services included in Scope of Work, and contract with required provider types including critical access providers, FQHCs and RHCs to assure compliance with State timeframe requirements. Key strategies for these vendors to identify providers for recruitment are highlighted in Table V.I.33-1.

Table V.I.33-1. Partner Strategies to Identify and Recruit Specialty Providers.

Partner	Non-network Provider Recruitment Strategy
IngenioRx	▪ In 2021, two compete pharmacy audits concluded that we were contracted with every available pharmacy in the state. Since then, we have added new pharmacies as they have opened, and work with the State to identify high-volume and rural pharmacies ▪ Review pharmacies that specialize in limited distribution drugs (LDDs, drugs that have special safety, storage, or administration requirements) to make sure we have good coverage and access to necessary drugs within the network, or work through the SCA process to make sure members can obtain LDD drugs ▪ Follow up on requests from the State, members, or their caregivers
Liberty Dental	▪ Leverage available data and Liberty Dental market knowledge, including identifying employees who have left a practice to start their own ▪ Engage existing Liberty Dental Medicare Advantage providers, existing Medicaid providers (prioritizing high-volume Medicaid providers based on members served/claims dollars based on available DHHS data), and critical access providers ▪ Review third-party provider report focused on specialty providers ▪ Review DHHS Provider Master List for recent additions ▪ Review out-of-network provider claims, provider directories for other programs, and dental association members (particularly focused on providers in underserved areas) ▪ Follow up on requests from members and other providers
ModivCare	▪ Offer distinct programs for rural communities including ModivCare's own rural rideshare service, Provado Mobile Health, with drivers including Certified Nursing Assistants, Home Health Aides, Direct Support Professionals, Certified Medical Assistants, and Personal Caregivers who specialize in working with members with high acuity needs ▪ Actively develop and continually improve an innovative app that makes it easy for volunteers, family members, friends, and members themselves to make connections to care, simplifying mileage reimbursement while preventing fraud and abuse

Our partners have designated Provider Relations staff for hands-on engagement in provider recruitment efforts. For example, IngenioRx will send prospective network providers a solicitation packet, including a contract and full description of network requirements, by mail or fax; and will reach out to non-network pharmacies in desired locations via phone and follow up with a solicitation packet, as appropriate. Network enrollment staff will follow up with solicited pharmacies by phone to discuss unresolved issues and answer questions. When IngenioRx has the signed agreement in-house, the pharmacy effectively becomes part of the network within three to five business days.

Our dental partner has prior Nebraska experience and is familiar with the dental delivery system and unique member needs. The ***Liberty Dental Network Development Work Plan, presented in Attachment V.I.33-1***, is a blueprint for building a statewide network. The network plan contains strategies for recruiting and retaining providers, identifying, and addressing network gaps, planning for future needs, measuring and improving timely access to care, and improving network quality. This plan focuses on recruiting dental providers to meet the cultural and linguistic needs of members. Liberty Dental leverages electronic contracting and credentialing processes to reduce provider administrative burden, offering a pre-filled application and transparency on the status of their application throughout the process.

We Will Leverage Our Parent Company's Expertise to Develop a Robust Network for Our HIDE DSNP. Our parent company brings extensive national experience implementing DSNP model in 22 states and will ensure Healthy Blue is prepared to meet all operational requirements to develop and implement a HIDE DSNP by January 1, 2024 and support the State with a phased alignment strategy to include implementation of an additional DSNP for unaligned and partial enrollees. Our affiliates' DSNP experience in states like New Jersey, Tennessee, New York, Washington, Colorado, Texas, Florida, and California lends us insights on best practices and potential pitfalls to avoid around key elements like data and benefit coordination. Our experience includes coordinating the delivery of Medicare and Medicaid benefits under a single entity, providing coverage for primary care, acute care, BH, specialty care and ancillary care, using aligned care management and specialty care network methods for high-risk beneficiaries. We will employ policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement, and we are fully prepared to build upon our network to meet the CMS Health Service Delivery requirements. We are offering Medicare Advantage contracts to our existing network and identifying gaps that need to be contracted for Medicare Advantage, to serve our HIDE DSNP members. During recruitment we will help providers with any administrative or logistical issues to participate. We have expertise to support benefit integration, wrap around coordination, and are assessing the need for additional resources.

Making Investments in Provider Workforce Expansion and Resources. We are engaging in innovative, collaborative programs, including providing a Healthy Blue Rural Health Endowment with the University of Nebraska Medical Center. [redacted]

Ongoing Monitoring, Oversight, and Intervention Assure MLTC's Network Standards are Maintained

Our local Network Managers and Provider Experience Representatives take a proactive, continuous data-driven approach to verify ongoing compliance with access and availability standards. Our Provider Experience team reviews data continuously and presents it at monthly operations meetings. Our Provider Advisory Committee (PAC), which meets quarterly hosted by our Provider Experience team, reviews the data, makes recommendations to address identified issues, and tracks issues through resolution. We also conduct quarterly network adequacy reviews and identify current and additional opportunities as a part of our Network Development Plan. Our

Network Scorecard captures network adequacy as well as provider performance, availability, servicing, unit costs, and costs of care. The yearly plan update is an opportunity to review current network status, acknowledge accomplishments, and update outreach and recruitment strategies and activities for the coming year to meet growing and changing member needs. Table V.I.33-2 summarizes network monitoring, with additional details following.

Table V.I.33-2. Proactive Network Monitoring and Development Activities in 2022.

Network Monitoring Activities	Frequency
Provider Network Change Reports. Allows analysis of network adequacy, especially in rural/frontier counties	Monthly
GeoAccess Reports. Evaluates time/distance standard compliance, opportunities to recruit providers	Quarterly
Quality Dashboard. Quality trends and Care Gap data is shared with providers	Monthly
Provider Efficiency. Cost of Care reviews identify provider outliers in utilization, result in provider education/ support to assist with administrative efficiency	Ongoing
Appointment Availability. Validates providers have adequate capacity, through surveys of appointment wait times	Quarterly
Out-of-network Monitoring. utilization reviewed by health services and network teams to identify opportunities for recruitment	Monthly
Open/Closed Panels. Provider Relations follow up with PCPs with closed panels to identify/address cause	Ongoing
Grievance and Appeals Monitoring. The Network Management and Provider Experience team reviews trends	Ongoing
Medicaid Expansion. Monitor impact of expansion to ensure network can meet unique needs of population	Ongoing

Time and Distance Standards. Healthy Blue's Regulatory and Compliance Reporting team conducts quarterly accessibility analyses using the minimum contract standards for GeoAccess. We use GeoAccess software (Quest Analytics) to verify the adequacy of the geographic distribution of its PCPs, high-volume specialists, pharmacies, BH (including Substance Use Disorders) outpatient services, BH inpatient and residential facilities, and hospitals, across urban, rural, and frontier areas. These reports compare the existing membership against the contracted provider locations. The Network Management team uses the analysis to identify gaps and target zip codes and provider types identified as at risk for failure to meet contractual standards. Our dental partner uses similar GeoAccess assessments to verify compliance with time and distance standards and will use a recruitment dashboard to monitor the status and geographic distribution of the network at least weekly and sometimes daily as they develop our dental network.

Open Panel Review. Healthy Blue also conducts open/closed panel analyses as part of our scorecard review. In 2021, 99.52% of our Network PCPs had open panels. We prioritize engaging providers with closed panels in areas with limited access, working with them to make sure they understand contractual obligations around open panels and identifying solutions to overcome barriers the provider may have to keeping their panel open.

Appointment Availability and After-hours Access. Healthy Blue hired a vendor (SPH Analytics) to conduct quarterly telephone surveys to providers to assess appointment access/wait time, and after-hours access standards – detailed in V.I.36. In Q1 2022, appointment compliance had improved across nearly all provider types compared to Q4 2021, with PCPs and high-volume specialists 100% compliant in Wait Time requirements. Nevertheless, Healthy Blue is committed to improving appointment availability through Increasing provider education on availability standards and the requirement to complete appointment availability audits; validating phone numbers and active status of providers in our provider data and directory to improve survey participation; and holding discussions around appointment availability and access standards during Joint Operating Committee meetings and provider town halls.

Culturally Competent Providers. We survey our Providers for languages they and their staff speak fluently and for ethnicity. We incorporate this information into our searchable Provider Directory so members can find local providers with on-site language compatibility. Through our Medicaid Training Academy, we offer providers cultural competency trainings including My Diverse Patients, Improving the Patient Experience (with continuing medical education offered), and Cultural Competency and Patient Engagement.

Our dental and transportation partners are also dedicated to providing culturally competent care. Liberty Dental's Dental Plan includes a focus on recruiting providers representative of the racial/ethnicity of the membership and has an experienced Tribal liaison to work with providers serving Tribal members. Our NEMT partner offers a robust network of qualified providers and trains drivers on safety and cultural sensitivity. ModivCare will also offer multi-lingual customer service representatives for maximum availability during all shifts and oral interpretive services available through a third-party partner, Voiance over-the-phone interpretation services.

Leveraging Member Characteristic and Utilization Data to Identify Emerging Trends and Needs. Healthy Blue conducts member population health assessments to understand member characteristics, needs, and socioeconomic challenges. This includes age, race, ethnicity, language, housing, literacy, and whether the person is living with a disability. We align member geographic distribution, health characteristics, and current provider network distribution to identify existing network challenges. Healthy Blue also tracks and assesses service utilization to understand current needs, future trends, and opportunities for intervention. We track Healthy Blue members utilization rates, including admissions rates, 30-day readmissions rates, emergency department visit rates, and generic prescription drug utilization. We track chronic conditions to understand member health needs and future utilization trends; and we closely monitor out-of-network utilization patterns to identify network engagement and contracting opportunities. In addition, we review language line translation services and in-person interpretation services to validate known member demographics, anticipate future translation service needs, and work proactively with providers in areas with a growing population of non-English speakers to assure providers are aware of their obligations to provide Culturally and Linguistically Appropriate Services and of Healthy Blue's tools to support them.

We Support Providers to Promote Retention and Assure a Robust Network

Our ***Provider Promise***, to simplify health care so providers can focus on health, underpins our approach to our provider services program and promotes provider retention in our network. Our PAC provides the organizational infrastructure for our provider collaborations. We have established policies and procedures (P&Ps), built on our Nebraska experience as well as best practices gleaned from our affiliate health plans operating in 25 additional markets. Our P&Ps assure that we fully support our provider community and that our provider services program meet or exceed industry standards. When a new provider joins the Healthy Blue network, we provide them a link to our provider handbook and a virtual orientation covering topics such as operations, coverage policies, clinical practice guidelines, provider responsibilities and standards, and provider supports.

> *Our experience working with [Healthy Blue] over this past year has been overwhelmingly positive which has led to improved patient care and outcomes. When questions come up, no matter the topic, we have been very pleased with the turnaround times for the answer. This includes billing and coding questions and claims. I have personally found the Healthy Blue website easy to navigate and helpful in locating the Nebraska Medicaid Preferred Drug List.*
>
> **Benjamin Thayer, MD**
> BCH Gage County Medical Clinic
> NE_HH22_Q33_BenjaminThayer_TST_02

Our *Nebraska-based Provider Experience team supports all providers*. Provider Experience Representatives provide one-on-one support and proactive engagement to every network provider who joins our network and ongoing. We have a ***dedicated Provider Experience Representative focused specifically on our FQHC providers***, contacting all FQHCs at least quarterly and visiting each location at least once per year to establish and retain clear lines of communication with some of our highest-volume providers. We continue enhancing our Provider Experience team, including the addition of three new full-time staff to assure we meet our commitment to respond to inquiries within 24 to 48 hours to expedite resolution and encourage ongoing Provider engagement and retention.

[redacted]

Seeking Provider Input. Our Provider Experience Representatives engage in dialogue and seek feedback from providers through quarterly town hall meetings, Joint Operating Committee meetings, and monthly on-site and virtual meetings with key providers (such as high-volume PCP groups, FQHCs, Tribal providers, and large hospital systems). Our Provider Experience team provides ongoing provider training and tutorials to support ongoing provider satisfaction and retention. The team also participates in numerous virtual conventions and State association conferences throughout the year, including Tribal Association meetings, and Rural Health Conference, which offer an opportunity to foster relationships with providers serving some of our most vulnerable members and learn more about concerns and barriers specific to those populations. Our clinical teams also engage providers, providing technical support to foster more effective and efficient health care delivery.

Our dental partner seeks provider feedback for dental network recruitment and retention. They hold focus groups and individual meetings with providers to identify and address any concerns including provider network challenges and opportunities.

Assuring All Network Providers Understand Nebraska Medicaid Policies. We go above and beyond to assure providers understand Nebraska Medicaid policies by putting policies in provider contracts and provider handbooks, discussing them in new Provider orientations and subsequent trainings, and leveraging our Provider Experience Representatives to reach out when there are policy changes. If a provider does not meet the availability standard or is out of compliance with other Nebraska Medicaid requirements, their assigned Provider Experience Representative reaches out to the provider to discuss the issue and to develop a remediation plan. We follow up with a letter reiterating the performance standard and contractual requirements and resurvey the provider for compliance in the next quarter the issue has been resolved. If retesting does not show improvement, we initiate an escalation process, which may involve re-education and medical director outreach.

[redacted]

Reducing Administrative Burdens. We encourage Providers to leverage our growing number of refined self-service tools to address common challenges quickly and easily. We offer training and support from our Provider Experience Representatives to help Providers understand the tools that are available, how to use them, and why using the tools will make operational challenges easier to navigate. We also take feedback from forums, town halls, and other interactions with Providers to identify key challenges and barriers for providers and we use the feedback to develop new tools, policies, and processes to reduce provider challenges.

No. 34

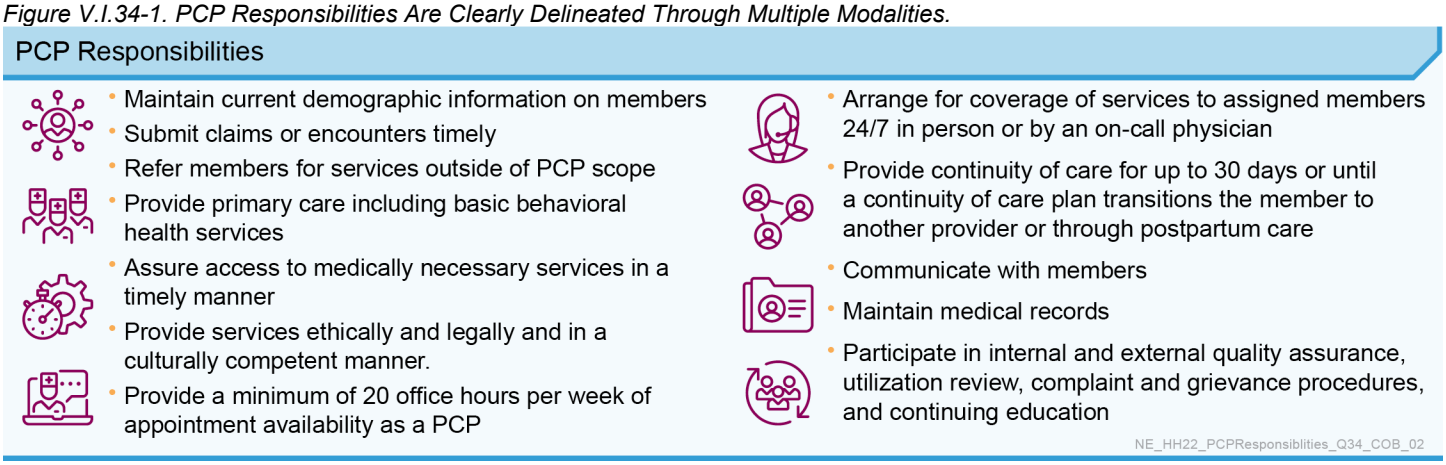
Healthy Blue Verifies That PCPs Perform Their Responsibilities

As members' entry point into the health care system, PCPs are essential to the Healthy Blue program. With a focus on the Quadruple Aim (improving population health, reducing costs, enhancing patient experience, and improving provider satisfaction), we want the PCPs in our network to consider us their partner rather than simply a payer. Building this relationship requires collaboration and communication, and making sure PCPs understand and fulfill their responsibilities. Our Provider Experience team works with PCPs to improve communications and helps PCPs and other essential providers understand their role. We have many processes for monitoring and helping PCPs meet expectations.

Provider Agreements Define Roles and Expectations. Written agreements with providers stipulate that they will fulfill program requirements and responsibilities. These requirements support our objectives that providers act in the best interest of members and meet Healthy Blue's expectations, which align with MLTC goals.

We Inform PCPs About Their Responsibilities Through Many Venues. We communicate all provider responsibilities during new provider orientation and thereafter in communications, engagements, and trainings. All PCP responsibilities are detailed in our provider handbook, available on-demand on our provider portal, and in related policies and procedures. The provider handbook is developed as a comprehensive and user-friendly resource to inform our network providers of program guidelines and requirements, covered services for members, provider roles and responsibilities, contractual information, and various requirements under State and federal law. We routinely ask providers for feedback on the usefulness of our provider handbook and other educational and communications. Figure V.I.34-1 presents key PCP responsibilities delineated in the provider handbook.

Figure V.I.34-1. PCP Responsibilities Are Clearly Delineated Through Multiple Modalities.



Processes to Monitor and Verify PCP Fulfillment of Role

Healthy Blue uses multiple processes to monitor and verify that PCPs are performing their responsibilities.

Site Visits. The Provider Experience team conducts ***routine site visits*** to our network of providers. The frequency varies based on size and experience of the provider group. [redacted]

If a PCP is found to be out of compliance with any of our standards, the first step is to review the finding with the PCP along with the standards, and then remeasure. If the correction is not evident, a formal corrective action plan (CAP) is put in place with the PCP along with the timeframe for remeasuring compliance. Our goal is to work with PCPs to help resolve any barriers and assure their compliance. If despite efforts the problem persists, further action is taken. This could include freezing the provider's panel or terminating the PCP contract. ***There are no network providers currently with a CAP in place.***

Credentialing and Recredentialing Process. As detailed in V.I.39, our credentialing process makes sure that providers joining the Healthy Blue network meet all federal, State, and Healthy Blue requirements. This includes compliance with Title II and III of the ADA and Section 504, which require that providers offer individuals with disabilities full and equitable access to their health care and service facilities. Healthy Blue ***recredentials*** providers at least every three years, whereby our credentialing partner verifies credentials that may have changed since initial credentialing, such as licensure, certifications, health status, and performance including, but not limited to, complaints, malpractice experience, and loss of hospital privileges. They review reports from the Special Investigations Unit and other internal departments that may reflect on the provider's professional conduct and competence.

Peer Review. We work in partnership with providers to continuously monitor the quality and appropriateness of care in accordance with our peer review policies and procedures. Peer review responsibilities are to:

- Participate in the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

If an investigation of a member grievance results in concern regarding a PCP's compliance with community standards of care or service, this will be referred to peer review including investigation of physician actions by the medical director. The medical director:

- Assigns a level of severity to the grievance
- Invites the cooperation of the physician
- Consults with and informs the Provider Advisory Committee (PAC)
- Informs the PCP of the committee's decision, recommendations, follow-up actions, and/or disciplinary actions to be taken

We report outcomes to the appropriate internal and external entities, including the Quality Assessment and Performance Improvement Committee (QAPIC). The peer review process is a major component of the PAC's quarterly agenda.

Access to Care Monitoring. We routinely monitor providers' adherence to access to care standards and appointment wait times. PCPs are expected to meet federal and state accessibility standards and the standards defined in the ADA of 1990, making services accessible to all members. We review these topics in provider orientations and trainings and monitor compliance during site visits. In addition, quarterly telephone surveys monitor compliance with appointment availability and wait times and after-hours access to care, detailed in V.I.36. In our Q1 2022 survey, PCPs and High Volume specialists were 100% compliant in wait time requirements. Non-compliant providers are re-surveyed the following quarter.

Ongoing Analyses. Healthy Blue's analyses of member complaints and grievances, annual member satisfaction survey, member calls, and utilization patterns also help us identify PCPs and other providers who may not be fulfilling their responsibilities. Our Provider Experience Representatives follow up and investigate indications of Provider contract noncompliance. Additionally, at our Joint Operations Committee meetings, there is a standard agenda to review provider performance and standards.

Partnering With and Supporting PCPs in Performing Responsibilities

Provider Promise

Our ***Provider Promise***, to simplify health care so providers can focus on health, underpins our approach to our provider services program and helps providers, including PCPs, perform their responsibilities effectively and efficiently. We engage in systematic and meaningful outreach with providers and act on the feedback we receive to continually improve our program to make it easy for providers to care for members. Our Provider Services Organization is composed of specialized teams (detailed in V.J.41) that collaborate with providers to implement our Provider Promise. They include Network Management, Provider Experience, Care Delivery Transformation (CDT), Practice Transformation Consultants, and MCH/EPSDT Coordinator. Our PAC provides the organizational infrastructure for our provider collaborations. Our provider website, provider portal, toll-free telephone line, and new Provider Chat function further support PCPs by promoting communication; access to member data, prior authorization, and claims information; and links to additional resources.

Provider Experience Representatives. Our dedicated Provider Experience team provides ongoing support to providers in fulfilling their contractual responsibilities and holds them accountable. This team uses our management information system to proactively track provider contract compliance, performance, and experience. We track all calls from and about our PCPs and meet regularly to review their performance indicators, and work with providers to identify and address barriers to meeting their responsibilities. We also provide training and education tools and provide a forum for discussion of upcoming changes and their role in the Quadruple Aim. Through communication, engagement, and peer review, we are transitioning from payor to partner.

[redacted]

[redacted]

No. 35

Healthy Blue Assures Members Have Access to High-quality Specialty Providers

Provider Promise

Healthy Blue is dedicated to improving lives, promoting healthier communities, and making health care simpler. Access to providers, including specialists, whether through geographic accessibility or timely appointments, is the cornerstone of care delivery. As an incumbent MCO for more than five years, Healthy Blue has a unique understanding of the Nebraska provider landscape and the challenges we must overcome to assure member access to specialty physical and dental health care and choice. We are currently working with Liberty Dental Plan, an experienced Nebraska dental provider, to provide dental care beginning in 2023.This includes assuring member access to dental specialty care, such as pediatric dentists, endodontists, oral surgeons, orthodontists, pedodontics, periodontists, and prosthodontists, in all Nebraska regions.

Healthy Blue goes beyond recruitment to enhance access to specialty care through initiatives such as telehealth, mobile services, enhanced reimbursement through value-based purchasing (VBP) offerings, and community paramedicine. We offer training and education to retain high-quality specialists. In line with our Provider Promise, we also offer supports and tools that simplify and reduce provider administrative burden and allow providers to focus on providing care. As testament to our success, in 2021 we found that almost all Healthy Blue members have almost 100% access (as measured by time and distance standards) to critical specialists, including cardiology (99.9%), neurology (100%), hematology/oncology (100%), OB-GYN (99.7%), and orthopedics (100%).

Innovative Strategies to Identify Specialty Types for Which Member Access Is Limited

Healthy Blue uses a multipart, proactive approach to identifying specialists to which member access is limited. We document our approach in our Nebraska Network Development and Management Plan. With oversight and reporting into the Quality Assessment and Performance Improvement (QAPI) and Dental QAPI Committees for monitoring, analysis of trends, and identification of opportunities for improvement, Healthy Blue diligently monitors network adequacy, anticipates future needs, and promptly identifies existing and potential gaps to make sure members have access to high-quality specialists. We continually assess the needs of all members (for example, demographic, medical, socioeconomic, cultural, chronic care, and disease status) against our existing network as well as utilization patterns, including out-of-network (OON) referrals. We seek critical insight and input from various sources (members, providers, our Provider Advisory Committee, DHHS, Care Managers [CMs], internal data, and others) to make sure that our network meets the needs of all members. In the future, we will also collaborate with the Liberty Access and Availability Committee to oversee dental network monitoring and identifying specialty dental providers for which access may be limited.

Quarterly, our Regulatory and Compliance Reporting and Provider Experience teams use Quest Analytics to monitor our network strength. We generate reports based on time and distance standards set by the State and use these reports to identify provider types and zip codes at risk of failure to meet contractual standards. Quest Analytics reports include:

- **Monthly Provider Network Change Reports** evaluates any changes within the network by geographic area, zip code, and provider type. The report identifies providers who have requested voluntarily termination from the network and the reason given, allowing Healthy Blue to proactively address issues and retain the provider. For example, a 2021 report identified a group of OB-GYN providers who voluntarily terminated from the network due to limitations on reimbursement for ultrasounds with no prior authorizations. To retain this critical provider, Healthy Blue adjusted the limitations to make sure there were no interruptions to member care.
- **Member Accessibility Summary** details the number and percentage of members with and without access to key specialists. We use this report to target our recruitment efforts.
- **Access Comparison Report** provides a graph representation of the point at which the percentage of members attain compliant status with the specified provider type and defined access standard.
- **Accessibility Detail Report** provides counts of members with and without access to care under the defined access standards. This includes provider counts and a member-to-provider ratio for the demographic or geographic area analyzed.
- **Member Accessibility Summary** provides an overview of the report's detailed analyses, detailing the number and percentage of members with and without access to key specialists.

Based on our Nebraska experience, we also use additional network monitoring activities, including those shown in Table V.I.35-1.

Table V.I.35-1. Healthy Blue Uses a Wide Variety of Tools to Monitor Our Network.

Tool	Description
Access and Availability Monitoring	▪ **Quarterly Specialty Analysis.** Provider Experience Consultants use these to compare annual network and access-related performance goals to our quarterly results, including time and distance standards, for specific provider types and locations, including cardiology, OB-GYN, orthopedics, neurology, and oncology. ▪ **Appointment Availability Surveys.** We use SPH Analytics to survey providers to determine appointment accessibility for Healthy Blue members for 13 appointment types, including routine, symptomatic, and urgent care. In Quarter 1 of 2022, we randomly sampled 797 providers, including 241 PCPs, 112 high-volume specialists, 58 high-impact specialists, and 65 other specialists (including noncompliant providers from the previous quarter). We found 99% of high-impact specialists, 82% of high-volume specialists, and 87% of other specialists were compliant with appointment standards. We sent noncompliant providers a letter asking for a corrective action plan, which we monitor closely until compliance is achieved.
Single Case Agreements (SCAs)	▪ We analyze OON utilization and SCA requests to identify potential access limitations and target these providers for recruitment.
Network Engagement	▪ We analyze participation of members, family members/caregivers, providers (including State-operated providers), and other community stakeholders in network-related activities. Based on stakeholder feedback, we identify opportunities to recruit additional providers or offer innovative solutions, such as community paramedicine, to meet member needs if there is limited provider capacity in a particular area. ▪ We review DHHS referrals to care, such as Division of Children and Family Services referrals to residential treatment centers, to identify network gaps as evidenced by the need for SCAs or OON authorizations.

Tool	Description
Member Profile	▪ We analyze member population characteristics and needs, including eligibility and enrollment, demographics (age/gender/race/ethnicity), cultural barriers, prevalent diagnoses, and utilization.
Member and Provider Satisfaction	▪ We analyze member and provider grievances, appeals and requests for hearings, member satisfaction survey results (for example, CAHPS®), and provider satisfaction survey results.
Grievance and Appeals	▪ Our Network Management and Provider Experience teams review access trends identified through the appeals and grievance process and reports to QAPI quarterly.
Employee Feedback	▪ Our local Network Management team collaborates with internal staff, including our Provider Experience team, CMs, Utilization Management team, and Operations team, to identify gaps and network development opportunities.
Cross-functional Leadership Meetings	▪ We convene cross-functional leadership groups, such as our Provider 360 workgroup, which reviews key network providers to identify areas of limited access, VBP opportunities, and quality performance. We also implemented a Rural Health Workgroup to identify and address challenges specific to rural areas. ▪ We meet monthly with the Nebraska Department of Children and Family Services to discuss coordination of care (including SCAs and authorizations) for members referred to residential treatment centers. If DCF identifies a gap in available providers, we outreach those providers for network recruitment.

Strategies for Identifying Dental Specialists for Which Access Is Limited. Healthy Blue will work with Liberty Dental to oversee the dental network to make sure members have access to critical specialists. Liberty Dental will use GeoAccess reports, open panel analyses, utilization data, member services data (including access-related grievances), input from their Customer Care team (responsible for helping members locate providers) and member outreach and outbound calls, reports on voluntary and involuntary terminations, and corporate dashboards to monitor access and availability of specialists. Liberty Dental will also assess availability through annual access surveys, secret shopper calls, provider feedback, and quarterly data reviews of appointment wait times, member grievances, satisfaction, and access surveys.

Initiatives for Increasing Network Specialty Providers

Healthy Blue realizes that network gaps may be due to a variety of factors, including population growth, provider attrition (that is, retirement, relocation, disenrollment from Medicaid), provider choice, panel closures, and geographical absence of a specific provider type to meet a unique need. Our Provider Experience team expands upon the Network Development and Management Plan to design targeted recruitment efforts to resolve those gaps. The plan identifies responsibilities, resources, and a timeline to correct the situation. Because providers have varying needs, circumstances, and knowledge of managed care, we tailor our approach to address each provider's specific needs. We then assign specialized staff resources and design and produce communications for provider outreach.

We also created a new Senior Network Manager position focused on working with and incentivizing rural providers to join our network to assure the Healthy Blue Network is meeting the needs of rural member and to address any gaps identified by the plan or the State. We highlight Healthy Blue initiatives for increasing network specialty providers in Table V.I.35-2.

Table V.I.35-2. Healthy Blue Uses a Wide Variety of Tools to Assure Our Network Meets Member Needs.

Initiative	Description
Leverage Provider Partnerships	▪ Our Network Management and Provider Experience teams encourage network providers to extend hours to expand access to more members when limited specialists are available in a geographic area.
Enhanced Reimbursement	▪ Healthy Blue is a leader in developing VBP programs. We take a broad-based approach — including as many providers as possible — to expand the reach of VBPs and advance the goals of transformational health management. VPB programs available to specialists include: [redacted]
Closed Panel Management	▪ Our Provider Experience team contacts providers identified with closed panels to determine the reason they closed the panel (for example, if the panel is closed because the practice is at full capacity or to all payers and/or MCOs), or if there is an issue with Healthy Blue that can be resolved. [redacted]
Telehealth	▪ If Healthy Blue identifies an access shortage for a particular provider type, we contact those providers to see if they are willing to expand access to their services through telehealth. We also provide PCPs with access to virtual consultations (e-consults) with specialty providers to help fill gaps for key specialist providers. This strategy is especially important for members in the rural and frontier counties. By using telehealth solutions, existing providers can expand their reach and service menu, which in turn increases their capacity to serve more members, both virtually and in person. Telehealth options include [redacted]

Initiative	Description
	▪ Liberty Dental will offer on-demand tele-dentistry during and after business hours. We are also exploring the addition of virtual specialty consultations for members from their dental providers office.
Telehealth Kits	▪ We will distribute telehealth kits to maximize the effectiveness of telehealth visits. These kits include medical devices, such as fingertip oxygen sensors, blood pressure monitors, and HbA1c home test kits, and will help members obtain more accurate readings during virtual sessions to better manage their health conditions at home. [redacted]
Mobile Health Care	▪ We are exploring partnerships with mobile providers, such as One World Community Health Center, to deploy mobile dental and physical health specialty services (for example, skin cancer screening, mammograms) to areas where access standards to specialists can be challenging.
Community Paramedicine	▪ We use MedAware, which uses specially trained paramedics to reach members in their home who would benefit from extra support in managing their health including chronic health conditions.
Transportation Support	▪ As a value-added service, Healthy Blue will use industry-leading Modivcare transportation, including providing Provado Mobile Health rideshare service in rural communities. This supports members in rural and remote counties in accessing specialty care in those counties where specialty providers do not exist.
OON Utilization	▪ We develop relationships with nonparticipating providers to allow us to work with them on a case-by-case basis to secure member access to the appropriate level of medically necessary care. Typically, we arrange care with OON providers by executing SCAs that authorize care for a specific member. Once we have an SCA in place, we encourage providers to join our network. If needed, we establish a permanent nonparticipating agreement with high-impact providers who do not wish to contract.
Community Partnerships	▪ We partner with community organizations to expand access and increase health equity. This includes the Omaha Black Doula Association, Macy Head Start (Tribal), Clyde Malone Community Center, and Norfolk Project Connect (Homeless). We are also offering a Malone Maternal Wellness Doula Scholarship to BIPOC individuals interested in becoming certified doulas to increase the number of BIPOC doulas in Lincoln and Omaha by 10. Liberty Dental also partners with academic institutions, such as the University of Nebraska Medical Center School of Dentistry, to expand access to dental care.
Contracting with Specialists in Contiguous States	▪ We analyze local referral patterns and recruit and contract with providers in contiguous states (for example, Colorado, Kansas, Iowa) to address specialty shortages. For example, we contract with the University of Colorado Medicine for specialty care to make sure our Western Nebraska Members have access to specialty care. The university has locations in various cities in Colorado and provides specialty care in neurology, cardiology, orthopedics, nephrology, endocrinology, urology, and gastroenterology.

Healthy Blue Also Focuses on Retaining Providers. Fundamental to Healthy Blue Network development and management, provider engagement and satisfaction contributes to provider retention and member access to care. In 2021, the Healthy Blue team conducted multiple training sessions, outreach activities, orientations, and visits with providers across the Healthy Blue provider network, including 307 provider visits across 48 counties and provider training on gap closures, authorization, telehealth, and Healthy Blue supportive tools (for example, the Provider Portal). Our Provider Experience staff hosted quarterly virtual and on-site town halls — which included Healthy Blue leadership — and monthly meetings and participated in numerous State associations and conventions throughout the year, including the Rural Health Conference and Tribal Association Meetings. We also use specialized Federally Qualified Health Center Provider Experience Representatives to reach out to all FQHC key primary and specialty care providers.

Challenges to Ensuring Access to Specialties Where Access Concerns Exist

Healthy Blue identified two primary challenges to assuring member access to specialty care: 1) a lack of specialty providers serving the Medicaid population and 2) general shortages of specialty physical and oral health providers in rural and frontier counties, including gaps in allergy/immunology, dermatology, endocrinology, and hematology/oncology. To mitigate these challenges, we developed and implemented targeted recruitment plans (for those counties where specialty providers exist but do not currently serve the Medicaid population). For members in counties where needed specialty providers do not exist, our CMs work with the member to identify options and arrange and support non-emergency medical transportation. This includes working with out-of-state providers, such as the University of Colorado, to provide specialty care for our members located near contiguous states.

In addition to our existing efforts outlined in Table V.I.35-2, we are exploring the opportunity to expand access to specialty services through virtual specialist consultations. Through ConferMED, Nebraska PCPs would have access to a variety of specialists, including those where access gaps exist in Nebraska, such as dermatology, allergy/immunology, and hematology/oncology. In our California affiliate, more than 80% of the PCPs using ConferMED reported being able to treat their patients within their practice without needing to send the patient out for a face-to-face visit with a specialist. We will continue to monitor the success of the program and work with MLTC to bring this solution to Nebraska.

No. 36

Monitoring and Ensuring Adherence to MLTC Appointment Availability and Wait Time Requirements

Healthy Blue has policies and procedures to monitor provider adherence to access requirements, including appointment (routine and urgent care), after-hours care, and wait times. We conduct surveys, site visits, and data reviews to monitor compliance; take corrective action for failure to comply; and support providers in meeting the standards. Healthy Blue will report findings and corrective actions to MLTC.

Healthy Blue is committed to maintaining a robust network, adequate in size and distribution of providers so that members receive care when they need it. We have developed and maintain a comprehensive provider network, including primary care, specialty care, and behavioral health (BH) providers in compliance with the standards set forth by MLTC. We are familiar with the CMS requirement for Medicare Advantage, including the Highly Integrated Dual Eligible Special Needs Plan. We have the mechanisms in place to monitor and determine compliance with requirements outlined by regulatory agencies, contractual requirements, or accrediting bodies. Healthy Blue requires that all network providers offer hours of operation that are no less than the hours of operation offered to commercial patients. Healthy Blue also requires its PCPs to arrange for coverage of services after-hours.

Educating Providers About Appointment and Wait Time Standards. During the contracting process, we inform providers of appointment availability and wait time standards to which they will be held accountable. We educate providers on these requirements at orientation and on an ongoing basis through training and in-person meetings. Our provider newsletters and provider handbook supplement initial training and serve as reminders for timely scheduling of routine appointments and triage requirement standards. We monitor access and availability to assure compliance with contract requirements, described throughout this section.

Monitoring and Reducing No-show Rates. Healthy Blue has incorporated no-show rate and wait time monitoring into our ***Provider Experience team site visits*** to providers. A Provider Experience Representative reviews the appointment availability standards with providers based on their specialty type, reviews the provider's policy on missed appointments, and asks/documents in the site visit tracking form:

- How the clinic is monitoring no shows and what efforts are in place to assure members attend appointments
- How the provider addresses barriers related to social determinants of health that affect appointment completion
- Whether there is collaboration between physical health providers and BH providers to help address barriers to keeping appointments
- The current wait time for a member to be seen by the office
- Whether telehealth services are being used to help address missed appointments

In addition, our care management process helps reduce missed appointments. When a member is engaged in care management, our Care Managers (CMs) assess the member's situation to identify and problem-solve any barriers that may impede the member from attending an appointment. For example, if the member does not have a working vehicle, the CM will provide the member information about options for transportation and assist with scheduling. We also offer gas cards if the member has a working vehicle, and we have flex funds that members may access if their vehicle needs repairs. The CM will reach out to the member and provider to make sure the member successfully completed the appointment.

Monitoring and Addressing Wait Lists. To monitor the practice of placing members who seek covered services on waiting lists, on June 1, 2022, we implemented a new process whereby our Utilization Management Reviewers assigned to BH facilities inquire and document any wait lists for the facility at least twice per month. All CMs have access to a spreadsheet of the wait lists, and members who are waiting for placement are discussed at our Integrated Clinical Rounds, which include our Chief Medical Officer and Director of BH. This process makes sure that we identify difficult-to-place members, those on a wait list, and those appropriate for a facility with a wait list. We interdepartmentally collaborate, problem-solve, and actively search for alternative placement to avoid disruption in care.

Key Processes for Monitoring Appointment Availability and Wait Times

Appointment Availability Audit Program. Healthy Blue's Appointment Availability Audit program measures wait times for various appointment types. The objectives are:

- To comply with state regulations set forth in Healthy Blue's contract with the State
- To provide quantifiable feedback to Healthy Blue regarding provider adherence to the access and availability standards set forth by Healthy Blue in compliance with appropriate state regulations and requirements
- To confirm whether the provider practice is open to new members
- To provide ways Healthy Blue can improve the services provided to its members

We conduct a quarterly ***telephone survey*** using a computer-assisted telephone interviewing methodology. They survey a random sample of all contracted providers, including PCPs, specialists, BH providers, and pediatricians, as well as noncompliant providers from the prior quarter. A script includes scenarios for 13 types of appointments: urgent care; symptomatic acute (sick) care; routine care; preventive care; prenatal care; family planning; outpatient treatment post-inpatient discharge; initial visit routine care; follow-up routine care; emergent care; non-life-threatening emergency; wait time; and notify members of wait time.

The survey report includes data at the practitioner level, allowing us to conduct practitioner-level analysis across all PCP types, high-volume providers, and high-impact specialists. Results are based on self-reported provider data and indicate the percentage of providers who meet the standards at the time of survey completion. The Q1 2022 survey found the following:

- From Q4 2021 to Q1 2022, among survey respondents, appointment availability compliance increased as a whole and for PCPs, high-volume specialists, high-impact specialists, and BH providers
- PCPs and high-volume specialists were 100% compliant in wait time requirements
- Radiology providers were 100% compliant overall and for urgent care and routine care appointment availability
- High-impact specialists were 100% compliant in notifying members of wait time
- Among providers who were re-surveyed because they were noncompliant the prior quarter:
  - In 2022, 86% were compliant, including 92% of PCPs, 100% of high-impact specialists, and 91% of pediatric providers
  - Pediatric providers were 100% compliant in urgent care, symptomatic acute (sick) care, and emergent care appointment availability

We conduct outreach to individual practitioners found to be noncompliant as an integral part of our survey process. Provider Experience Representatives conduct education and training regarding the standards of access for all providers identified in the surveys who did not meet the requirements. As noted, we re-survey all providers found initially to be noncompliant to assess improvement. We are also validating phone numbers and the active status of providers in our provider data and directory to improve survey participation.

After-hours Access to Care Audit. Healthy Blue conducts an After-hours Access to Care audit to measure the availability of Healthy Blue's contracted providers after-hours. Our after-hours survey places phone calls to a random sample of contracted physicians' offices and providers who had been noncompliant in the prior quarter on Monday through Friday between 5 and 9 p.m. local time. The surveyors record how each call was answered (such as live person, answering machine, or automated message). If connected to an answering service, interviewers then asked respondents if a patient who was calling after-hours could speak with a medical provider within 30 minutes. In our Q1 2022 survey, 95% of answering service staff in the random sample indicated compliance with speaking with medical providers within 30 minutes. Among re-surveyed providers, 99% of answering service staff indicated compliance**.** Provider Experience Representatives conduct outreach and education with noncompliant practices.

Monitoring Member Experience and Utilization Patterns to Assess Access and Wait Times. Healthy Blue will conduct analyses to monitor members' experience with accessing providers, using utilization data, out-of-network services data, and Availability and Accessibility reports. Our Network Management, Provider Experience, and Community Relations teams work collaboratively to review results and analyses at least annually to inform outreach to providers and address identified issues. We will monitor and identify provider availability issues through:

- Review of member complaints and grievances related to appointment access
- Annual CAHPS® survey to obtain member satisfaction with provider wait times and access to care
- Calls to the toll-free 24-hour Nurse Helpline due to inaccessibility of PCP
- Analysis of member service utilization patterns, including utilization of the emergency department and inpatient admissions and readmissions, to identify specific communities or practices with inadequate access to their providers

Partnering with Providers to Improve Adherence to Appointment Access Standards

We partner with providers to meet access standards. If we identify a pattern of noncompliance with appointment availability or wait time through our audit programs, site visits, or member feedback (such as member grievances), our Provider Experience team sends a written notice to the provider and:

- Investigates the issue and develops an action plan to bring the provider into compliance
- Meets with the provider to discuss the plan and standards, formalize the plan, and obtain agreement for follow-up reassessment
- Monitors the plan to make sure the provider completes the critical tasks according to schedule and conducts a follow-up audit three months after resolution
- Provides guidance if the provider does not achieve compliance or remains noncompliant

Healthy Blue may also impose sanctions, such as limiting the provider's panel size. Finally, if providers do not correct their deficiencies after our continued improvement efforts, we may terminate the provider from our network. However, we work with providers to help them become compliant to enhance care access for our members.

Healthy Blue seeks providers' input on how to best address noncompliance and improve access overall. For example, results of the appointment availability survey are reported through the Provider Advisory Committee (PAC) to the Quality Assessment Performance Improvement Committee. At its 2022 meeting, the PAC was presented with the survey results and reviewed and approved the following action steps:

- Offer telehealth for symptoms and conditions where appropriate
- Encourage the practice to allow for urgent care appointments
- Continue Provider Experience Representative outreach to all noncompliant providers
- Develop a newsletter article specific to OB-GYNs regarding high-risk appointment time frames by Q3 2022
- Educate members and providers on urgent care and specialists appointment standards by Q3 2022
- Continue to identify and contract with specialists

Appointment availability and access standards are also a standing topic in Joint Operating Committee meetings and Provider Town Halls.

No. 37

Approach to Promoting Patient Centeredness/Patient-Centered Medical Homes (PCMHs)

At Healthy Blue, improving population health with patient-centered solutions is at the heart of everything we do. Our solutions are evidenced-based, creative, agile, and forward thinking, and founded on patient-centered principles and practices to facilitate services that are responsive and meaningful to individuals' evolving preferences, needs, and personal goals. We inform our patient centeredness/PCMH approach using best practices and lessons learned that have helped us achieve improved quality outcomes across our parent organization and affiliate markets. We embed our patient-centered approach in our population health model which uses continuous quality improvement and comprehensive data analytics to assess and adjust strategies to drive improved health for members. We also incorporate NCQA-recognized PCMH principles and the joint principles of the PCMH developed by the American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association into our population health model.

We educate and train Healthy Blue employees, including our Member Services Representatives, on the patient-centered approach to care, best practices, and strategies for engaging members and we provide continuous training, coaching, and supervision that support employees' consistent application of these principles when serving members and providers. Through our Medicaid Training Academy, Healthy Blue also gives providers access to an extensive library of training opportunities and topics based on patient-centered principles. This includes trainings on a patient-centered approach to care, and patient-centered care and cultural change. We also offer specific training for specialized providers, such Long-Term Care (LTC) and Long-Term Services and Supports (LTSS) services providers, including LTSS patient-centered planning, the value of self-advocacy, and the patient-centered case management model.

Through our organizational experience, Healthy Blue has gained valuable insights into the best ways to support practice transformation as well as address barriers to achieving PCMH recognition. We will continue to support Nebraska practices that have already achieved PCMH recognition while identifying new practices that are good candidates for transformation. This includes practices with superior quality performance, prioritizing geographic areas where PCMH practices do not exist. We will assess individual and aggregate level provider performance within our PCMH model on an ongoing basis to identify opportunities for improvement and program enhancements. We will also monitor member satisfaction to make sure the PCMH model is improving their experience and promoting engagement. ***Our affiliates first launched PCMH models more than 10 years ago and currently support more than 30,000 patient-centered providers in advanced models across our affiliate markets today, including 23 clinics and an additional 82 PCPs NCQA-accredited as PCMHs in Nebraska.***

Technology Assistance to Help Providers Implement Patient Centeredness Principles

We have learned that for many provider practices, providing patient-centered care and the prospect of transitioning to a patient-centered PCMH model can be daunting due to a lack of staffing, time, or financial means. As a result, we work with providers to establish the infrastructure and provide the clinical and administrative support they need to be successful. Healthy Blue Provider Experience Representatives give providers with the tools, resources, and technical support needed to encourage bidirectional data exchange, including provider use of EHRs and connection with the State health information exchange (HIE), CyncHealth. This also includes offering financial assistance to providers who have not yet adopted EHRs or who wish to modernize their existing systems. In addition, to further support bidirectional data sharing, Healthy Blue opened secure file transfer protocol (SFTP) sites (valued at $1700) for providers in value-based purchasing (VBP) programs in 2022 at no cost to providers. We will continue this practice in 2023 as well as extend financial incentives to establish SFTP sites with all providers.

Healthy Blue also supports data exchange through our secure Provider Portal's (Availity) digital offerings, including Patient 360°SM. Patient 360°, part of our care management platform, Health Intech, was developed with provider input and offers an easy-to-navigate dashboard that gives providers information on gaps in care, claims, member eligibility and utilization, care management communications, and more. Through Availity, providers can view performance snapshots, performance metrics and trends (month-over-month, year-over-year), and more. We also work with providers to develop customized reports to support their PCMH efforts.

Healthy Blue Utilizes VBP and Incentives Methodologies to Support PCMHs

The goal of our PCMH program is to move from provider payer to provider partner. We do this in part by offering meaningful incentives and VBP programs that reward providers for achieving cost and quality goals and providing the right level of support providers need to truly transform their practices. Because providers have unique needs and differing levels of knowledge and experience with advanced payment models, we meet them where they are and assess their needs and current practices to move them along the VBP continuum as they demonstrate increased capacity. Our VBP offerings, shown in Table V.I.37-1, include a range of programs that support PCMHs. All programs align with the Health Care Payment Learning and Action Network (HCP-LAN) categories and principles of the Quadruple Aim.

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Healthy Blue Supports PCP Transformation Through Technical Assistance

We know that effective collaboration with our programs is essential to making sure that PCMHs can complete essential tasks and provide quality care. We also know the first step in making sure that PCMHs interact with our programs is educating them on the support programs we offer and how they will benefit their patients. Upon joining our network, we assign every provider a locally based Provider Experience Representative who is responsible for providing initial and ongoing training. In addition, we offer providers comprehensive tools, training, and dedicated local resources that will help them achieve their practice transformation goals, including:

- **Practice Transformation Consultant.** This position works closely with providers to make improvements in areas such as timely patient access, quality of chronic and preventive care, patient centeredness, cultural competence, and team-based service delivery. Additionally, Practice Transformation Consultants help clinicians and staff members develop the capacity for sustained change and improvement. This Consultant also provides providers with education, training, and technical assistance on NCQA Accreditation programs including PCMH and/or LTSS Distinction. The Consultant will work closely with our Health Equity Director and Provider Services Manager to identify and recruit new provider practices into the PCMH program. The Consultant will hold an NCQA PCMH Content Expert Certification, allowing them to effectively support providers with existing PCMH recognition and develop a methodology to identify and recruit new providers into the program.
- **BH-focused Practice Transformation Consultant.** This BH-focused Practice Transformation Consultant has a background in BH and focuses on assisting PCMH providers in achieving the NCQA Distinction in Integration of BH, including performing a gap analysis and implementing changes to align with the standard requirements of the BH Distinction.
- **Provider Coaching.** Healthy Blue Practice Transformation Consultants provide PCMH NCQA coaching sessions for all practices at any point during the performance year. Coaching sessions occur on-site or virtually and may include one-on-one coaching with physicians, office managers, Care Coordinators, and more. We individualize coaching plans to meet each practice's needs.
- **Customized Data Analytics.** Healthy Blue facilitates practice transformation success by delivering timely, actionable, and relevant information to PCMH practices. To help them monitor their performance, we will share customized data analytics, reporting, and performance management tools. Providers can examine performance and quickly identify opportunities for improvement. We will also give PCMH practices customized quarterly interim performance reports that compare their performance with that of their peers and against established benchmarks as well as an annual final performance report each year. If we identify a practice that is underperforming, we will incorporate a more robust, team-based, targeted approach that involves increased coaching hours, action plans, increased clinical support, and program reassessment.

Facilitating Specialty Provider Access and Care Coordination to Support Patient Centeredness

Members benefit from having a PCP who has earned the PCMH designation and is able to more proactively engaging in specialist referrals and care coordination. We offer PCMHs the right level of support to successfully perform specific tasks related to member care that include but are not limited to care coordination support. Care Coordinators perform referral tracking, follow-up, and coordinate care transitions to help assure that primary, BH, and specialty care clinicians are effectively sharing information and managing patient

referrals to minimize cost, confusion, and inappropriate care. We also offer medium and high-risk PCMH practice attributed members care management support. Along with outreach, coordination, and support to members, CMs offer training and support to PCMH providers in accessing services, member incentives, value-added services, and community-based resources. CMs also share monthly member stratification information so that the PCMH is aware of changes in the member's risk level to guide appropriate engagement. CMs also coordinate with the PCMH as needed, but at least twice per year, to discuss each attributed member's treatment plan, progress and challenges, barriers to care, new needs, coordination with other providers, and ways to close any care gaps. We invite PCMH providers to these conferences by mail, offer the option to choose an on-site visit or teleconference, and offer to reimburse them for their time to incentivize attendance. We will work closely with PCMHs, review member readmissions with them to assure they are managed, conduct rounds for high-risk members, and look for opportunities to provide additional support. We are also currently exploring the opportunity to expand access to specialty services through ConferMED virtual consultations. ConferMED offers PCPs access to a variety of specialists. In our California affiliate, more than 80% of the PCPs using ConferMED reported being able to help their patients without needing to send the patient out for a face-to-face visit with a specialist. We will continue to monitor success of the program and will work with MLTC to bring this solution to Nebraska.

Healthy Blue Efforts to Increase and Support the Provision of BH Care

Healthy Blue utilizes many initiatives to support the provision of BH care. Our BH-specialized Practice Transformation Consultant, described earlier in this section, works with PCMHs to achieve the NCQA Distinction in BH Integration. NCQA gives this distinction to providers that have the resources, evidence-based protocols, standardized tools, and quality measures in the primary care setting to support members' low acuity BH needs. The distinction recognizes the provider's ability to provide comprehensive, whole person care that go beyond the requirements of NCQA PCMH Recognition. Healthy Blue also supports PCMH provision of BH care through our telehealth program. Telehealth helps address barriers to BH care, such as long transportation distances, which is especially important in states like Nebraska where there is a predominance of rural areas. It also increases the likelihood that members with co-occurring BH/SUD conditions will seek treatment. Offerings include the use of the HIPAA compliant Telehealth OS platform (at no cost to the provider). [redacted]

Facilitating Data Exchange Among Providers

[redacted]

Methodology for Evaluating PCMH Performance

Healthy Blue will monitor and evaluate PCMH performance across established metrics on an ongoing basis to promote improved member outcomes through our Quality Assessment and Performance Improvement (QAPI) program. We evaluate quality improvement by tracking member outcomes and improvements in HEDIS® measures. We will also use the Provider's Performance Scorecard to monitor outcomes at the individual provider level. This scorecard contains analysis of provider performance on quality measures tied to incentives and a summary of current compliance rate and measures trends, as well as cost performance. [redacted] We can also drill down reporting to the member level to identify specific members or populations with current gaps. Healthy Blue will also monitor the overall success of the program by assessing PCMH performance against non-PCMH peers. This will include metrics such as ED utilization, readmissions, and nonemergency hospitalizations, as well as overall health outcomes and gap closures for their attributed membership.

No. 38

Process for Responding to the Termination or Loss of a Large Provider Group

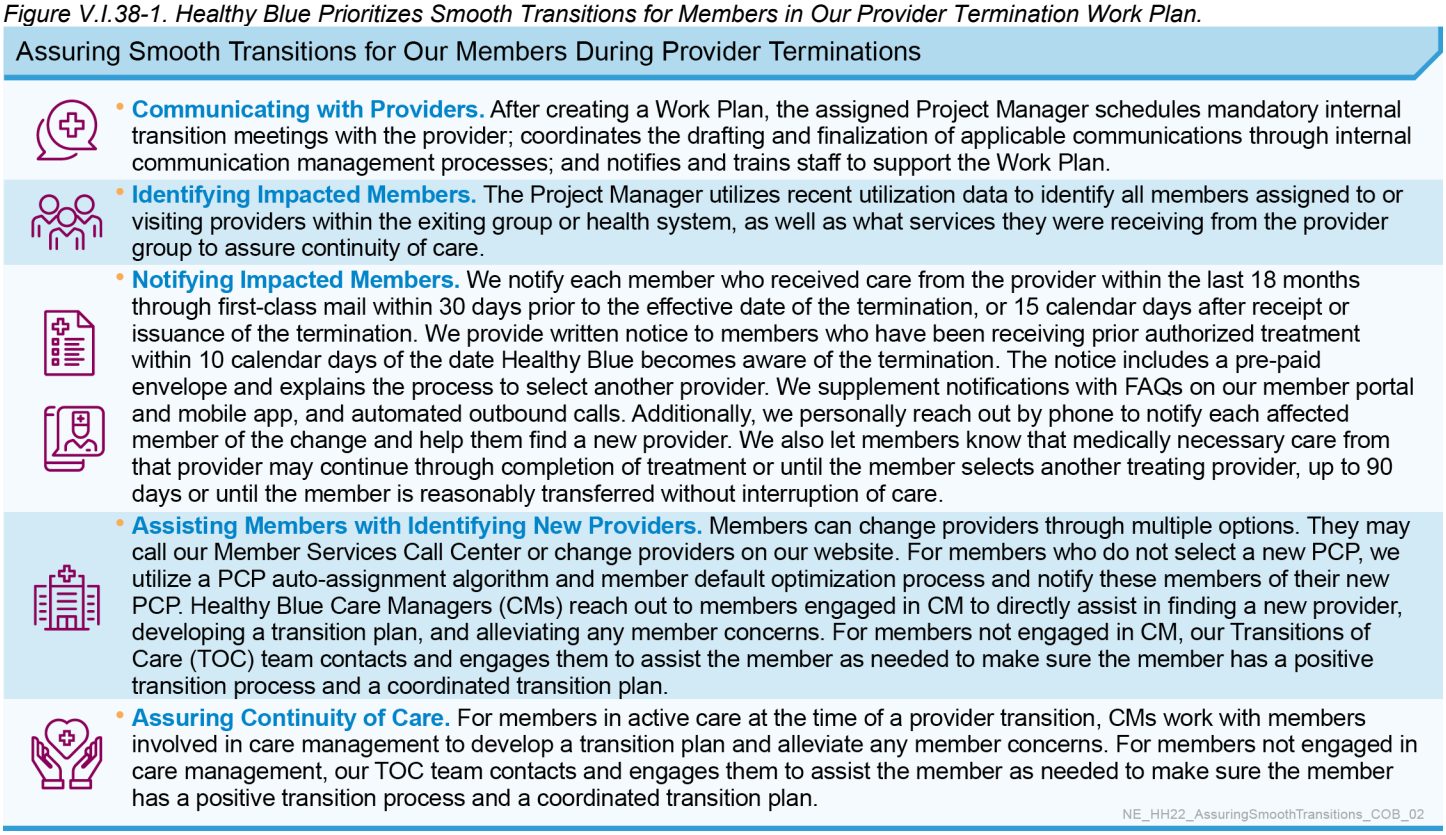
At Healthy Blue, members are our priority, and we are committed to connecting members with the services they need when they need them, and in the appropriate setting. We understand the impact that the loss of a large provider or health system (and small/medium provider groups, particularly in rural areas) has on member access and continuity of care, as well the significant challenge it poses to DHHS, other stakeholders, and our plan if not managed in an effective manner. ***We are proud to have never had a large provider termination.***

We always work to avoid provider network terminations. We developed our provider network management and servicing approach, which includes our local Provider Experience team, on the principles of maintaining strong and long-lasting provider relationships. They focus on retaining our current network providers through tailored provider engagement, access to training and education, incentives, and value-based purchasing (VBP) arrangements that allow providers to earn more, and by offering electronic and other tools that reduce administrative burden — such as online authorizations, electronic claims payments, and others. However, in the rare event of a large provider termination, we will execute established formal policies and procedures and systems in place that address MLTC and member notification and support member continuity of care during the transition. Additionally, our local Provider Representatives will meet with representatives of the terminated provider group representatives to set expectations for post-termination continuity of care, based on provider contract provisions and State requirements.

Provider Termination Work Plan

If the event of a large provider group termination or loss (or a small/medium high-impact provider termination in rural areas), Healthy Blue will assign a Project Manager who collaborates with our local Provider Experience team to develop and oversee the comprehensive Provider Termination Work Plan. Healthy Blue's Provider Termination Work Plan includes well-established processed for coordination with the State, our Pharmacy Benefits Manager (PBM), and other stakeholders, as well as processes to assure continuity of care for impacted members. In the Provider Termination Work Plan, we define the tasks we need to complete, assign a business owner for each task, establish start and finish dates and milestones, and implement a monitoring work plan to keep each task on track. Healthy Blue will submit our Provider Termination Work Plan and supporting documentation to the State within 30 business days of notifying the State of a large provider termination, and we will provide weekly status updates. Additionally, we will provide any supplementary information requested by the State within two business days of the request. We illustrate key activities of the Provider Termination Work Plan in Figure V.I.38-1.

Figure V.I.38-1. Healthy Blue Prioritizes Smooth Transitions for Members in Our Provider Termination Work Plan.



Notification to MLTC

The Healthy Blue Compliance team notifies MLTC of any provider terminations or losses through email within 10 days after receipt or issuance of the termination, in accordance with the Work Plan. For large providers, our CEO, Dr Robert Rhodes would reach out to the MLTC director with a courtesy call informing them of the event as soon as we learn of the termination. We will continue to keep MLTC abreast of the situation as it proceeds, at a cadence of their choice. We will also work directly with our MLTC Plan Manager and

Program Integrity unit, as necessary, in establishing our Provider Termination Work Plan, and collaborate with our Provider Services teams in undertaking actions to retain the provider, when appropriate.

Coordination with the Pharmacy Benefits Manager

Healthy Blue assures there is no impact to the member's ability to fill a prescription in the event of a network termination or loss of a large provider group. In the event of a network termination or loss of a large-scale provider group, in accordance with our Provider Termination Work Plan, Healthy Blue will collaborate with our PBM, IngenioRx, to make sure members experience a smooth transition. This includes assuring that all pharmacy claims continue to process at the point of sale regardless of the prescriber's provider network participation status if the provider has an active Medicaid State ID. If the provider no longer has an active Medicaid State ID, in accordance with State and federal regulations, the member's prescriptions, excepting controlled substances, will remain valid for one year following termination.

Healthy Blue Member Services Representatives (MSRs) and Care Managers (CMs), for those members in the care management program, will collaborate with the member to transition to a new in-network provider (detailed more fully below). This includes coordinating the transfer of member information, including the member's active prescriptions, to assure members do not experience a lapse in refills.

Automated Systems and Membership Support to Assist Impacted Members with Provider Transitions

Healthy Blue implements effective processes to assure that all member transitions are well coordinated and reflect member preferences. All Healthy Blue members can contact our MSRs for assistance with identifying and transitioning to new providers. We train our MSRs, as part of our member services call center, to provide information about transitioning from one provider to another. Healthy Blue MSRs will help members find the right provider to best meet their needs and understand their services and benefits. They will also help schedule provider appointments when needed. For members engaged in care management, Healthy Blue CMs provide an additional resource for assisting members involved in care management with provider transitions and coordinate care for members as they transition among providers. Members may also access our online Provider Directory, which we update five nights a week. Our Provider Directory enables members to select the most appropriate provider based on detailed information, including office locations, office hours, specialties, board certifications, accessibility for those with disabilities, age or gender served, and languages spoken.

Systems and Policies to Maintain Continuity of Care of Members Experiencing a Provider Transition

At Healthy Blue, the health and safety of our members is our priority. We will allow members to continue an ongoing course of treatment from their provider for the greater of 90 calendar days from the date the member is notified of the termination or pending termination, or 30 calendar days from the date of the termination unless the provider is being terminated for cause, in which case we will transition the member immediately to another provider for services. We will also extend this transition period if we determine that the extension is clinically appropriate, and we consult with the member and provider in making these determinations. We will continue the ongoing course of treatment while making the determination, and we will notify the member as expeditiously as the member's health condition requires, but no later than two business days. If we determine that what the member is requesting is not an ongoing course of treatment, we will issue the member an adverse benefit determination notice with information on the appeal process.

For any affected member, including members in an ongoing course of treatment, the Healthy Blue CM team will contact them directly by phone and in writing to facilitate continuity of care and help them find a new provider. CMs facilitate the confidential exchange of information between PCPs/PCMHs and specialty and BH providers. CMs also review member and provider requests for continuity of care and facilitate continuation with the current provider until they can complete a short-term regimen of care or the member transitions to a new provider. CMs coordinate with applicable providers to coordinate care and document services in our clinical system as part of our interdisciplinary treatment team process. If a hospital or facility terminates, we review surgeons and other providers who maintain privileges at the terminated hospital or facility and make appropriate arrangements to maintain hospital coverage or obtain privileges at another in-network hospital. If impacted members are receiving BH care from a terminating provider, the member's BH CM works closely with the member and the new provider to coordinate services.

Healthy Blue MSRs are also available throughout the provider transition process to personally assist affected members in transitioning to new providers. As appropriate, our Nebraska-based Community Health Workers and other specialize care team members, such as Certified Diabetes Educators, also work closely with our utilization management staff and Medical Director to thoroughly monitor care for members as they transition.

To support continuity of care, with the member's permission, we can share pertinent member information through Health Intech, our primary method for aggregating and sharing member care management information from all sources in one organized format, including health needs screenings, care plans, and utilization data, such as claims history, authorizations, immunizations, labs, and chronic care management. This system fully integrates with our MIS data. Health Intech is fully compliant with State and federal laws, HIPAA, and the HITECH Act and includes available data from Healthy Blue's care management and claims-processing systems, public health systems, continuity of care data (claims history or other information from LDH or other MCOs), and other payers and providers (pharmacy, lab, diagnostic, and EHR data).

Mitigating the Impact of Provider Loss or Termination in a Geographic Area with Provider Gaps

In the unforeseen event of a large provider group or health system termination, we implement our Provider Termination Work Plan. We also run updated network adequacy reports, analyzing the impact to accessibility to verify that we continue to meet the care and service needs of our members. If we identify any adverse impacts or gaps to our network in a geographic area where other providers of the same provider type are not available, our local Provider Experience team will develop strategic plans to remediate those barriers — either by supplementing access with alternative providers or through other means, including telehealth, as necessary. We will carefully review our existing network providers to help assure their access and availability remains within the requirements with the potential addition of new patients.

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No. 39

Healthy Blue Credentialing and Re-credentialing Processes

Credentialing providers is a critical component of Healthy Blue's contracting and quality management (QM) processes, which support improved provider selection and retention, and assures appropriate, high-quality care for Nebraska Heritage Health members. We only engage providers who are equally committed to improving the health of Nebraska's most vulnerable residents. We have extensive organizational experience in credentialing both Nebraska providers and Medicaid providers in 25 additional markets across the country. Our approach meets or exceeds all credentialing standards and protocols, including those required in 42 CFR Parts 438 and 455, Subpart E, and NCQA standards; we embed these standards in our credentialing policies and procedures.

> *For the past year, I had the honor of being on the Healthy Blue Credentialing Committee. It is important that measures are in place so that individuals on Medicaid are getting the best quality medical services and medical providers possible. it has been very rewarding to have such a role and see that [Healthy Blue] is doing such an incredible job in making sure this population gets the best care possible.*
>
> **Jeff Booher PT, ATC**
> Owner, Peak Physical Therapy and Sports Performance
> NE_HH22_JeffBooher_TST_03

To become a Healthy Blue network provider, providers must meet all federal, state, and Healthy Blue requirements, including compliance with Titles II and III of the Americans with Disabilities Act and Section 504. These regulations require that providers offer individuals with disabilities full and equitable access to their health care and service facilities. We make the credentialing process as easy as possible for providers to reduce administrative burden. Our Provider Experience Representatives are available to assist providers throughout the process, and we continually work alongside the State and our providers to navigate any industry changes, including Council for Affordable Quality Healthcare (CAQH) and Medicaid enrollment changes.

We also invest in operational resources and infrastructure to support credentialing and employ industry-leading tools, such as the standard CAQH Universal Credentialing Data source. For example, in 2022, Healthy Blue is investing in digital provider enrollment (DPE) as a new, quick, and intuitive way for State-enrolled/approved providers to join our network. We host the DPE in our secure provider portal (Availity) and uses CAQH ProView to extract data from the provider's CAQH profile. Providers can use CAQH to maintain their profile for submission to multiple organizations (for example, hospitals and health plans), eliminating duplicative paperwork for providers. In addition, the solution simultaneously credentials and contracts a provider as a best practice.

All network providers are recredentialed at least once every three years to assess whether they continue to meet credentialing requirements, consistent with NCQA standards. To assure ongoing compliance, the Healthy Blue Credentialing team, Accreditation team, and National Credentials Committee regularly review and update our comprehensive credentialing policies when NCQA, the federal government, or the State issues new standards or requirements.

Consistent with NCQA guidelines, Healthy Blue maintains a Credentialing Committee, chaired by Dr. Deb Esser, our Chief Medical Officer. The Credentialing Committee consists of representation from a culturally diverse range of participating practitioners throughout Nebraska, including representation from rural, suburban, and urban communities, and across provider types, including behavioral health (BH), general surgery, internal medicine, obstetrics/gynecology, pediatrics, family medicine, and emergency medicine. The Credentialing Committee uses a peer review process to make recommendations regarding credentialing decisions for application files that do not meet the criteria for which the Medical Director over the Credentialing Committee is authorized to evaluate and approve.

Credentialing Process

Healthy Blue's credentialing process meets all credentialing performance expectations, including credentialing providers, within 30 days. Healthy Blue encourages providers to use CAQH, which is free to providers, for initial credentialing, updating demographic and licensure information, and periodic recredentialing. CAQH meets industry standards for collecting the provider data used in credentialing and simplifies the credentialing application process, as noted above; it helps to assure the accuracy and integrity of the provider database.

Once Healthy Blue receives a provider application, a locally based Provider Experience Representative or contracting consultant confirms the provider network contract and the application in our credentialing intake tracker file, where it then moves through the credentialing workflow. As a first step, our Credentialing department reviews the application for completeness. A complete application is one in which the provider has provided all data elements our credentialing policies requires. If the application is not complete (for example, the provider has applied for but does not yet have hospital admitting privileges), we contact the provider up to three times for the information.

We start our 30-calendar day credentialing timeclock once the application is complete. Our credentialing partner then:

- Obtains primary source verifications required by NCQA standards and Healthy Blue policies, including State license, Drug Enforcement Administration certificate, malpractice insurance, education and training, work history, and board certifications
- Checks the federal Office of Inspector General (OIG) List of Excluded Individuals/Entities and the federal System for Award Management sanctions databases and the National Practitioner DataBank for information about provider exclusion, medical malpractice payments, and certain other adverse actions involving the practitioner or organization
- Checks state licensing databases for disciplinary actions and flags disqualifying criteria (for example, federal exclusion, no state license, no malpractice insurance) and any "deficiencies" (for example, disciplinary actions, malpractice lawsuits, and insufficient training for the specialty requested) that would cause the application to be "non-clean":
  - If the provider has malpractice or probation on licensure, the file may then go to the Credentialing Committee for further discussion
  - If the provider license is sanctioned/debarred or excluded from Medicare or Medicaid, we will deny the provider

Our credentialing partner then reviews the verification documentation and any deficiencies our credentialing partner identifies. If we determine that the provider meets State, federal, and Healthy Blue's credentialing criteria and NCQA standards (has no deficiencies and is therefore clean), we refer the application to the Medical Director for credentialing.

On occasion, providers whose application has a significant deficiency (for example, malpractices, previous action on license, multiple disciplinary actions, quality rating concerns—less than 1% of applications) may require further peer-to-peer discussion. We may refer these applications to the Credentialing Committee for additional discussion on inclusion in the Nebraska network. The Credentialing Committee reviews the file during scheduled monthly meetings or ad hoc meetings, when necessary, to assure application processes within 30 days.

If Healthy Blue declines to include an individual or group of providers in our network upon initial credentialing, we provide them with written notice of the specific reasons for our decision within 5 days of the decision, including information about their right to informal reconsideration. If a provider believes that we declined them in error because of inaccurate information, they may submit new documentation, which we will present to the Credentialing Committee for decision reconsideration.

Once the Medical Director or Credentialing Committee approves a provider for credentialing, the Healthy Blue Provider Database Operations team generates a letter to the provider approving their credentials. ***In 2021 and Quarter 1 of 2022, we completed credentialing for 100% of Nebraska providers within 30 days, including 381 applications and 248 applications in 2021 and 2022, respectively.***

Facility Requirements. As part of Healthy Blue's Uniform Credentialing and Recredentialing Policy, all health delivery organizations (HDOs) that fall within the scope of credentialing use a facility/ancillary application to make sure that they are licensed appropriately. HDOs include providers such as acute care hospitals, home health agencies, skilled nursing facilities, nursing facilities, freestanding surgical centers, and BH facilities that provide BH or substance use disorder treatment in an inpatient, residential, or ambulatory setting. The process for credentialing HDOs and facilities is the same as those described above, with two notable differences. First, HDOs complete a Healthy Blue credentialing application rather than the CAQH form. Second, an appropriate, recognized accrediting body must have accredited the HDO, or, in the absence of such accreditation, the HDO must have submitted an acceptable recent site survey by Medicare, the appropriate State oversight agency, or a designated independent external entity within the past 36 months. We will credential nonaccredited HDOs only if there is network need (for example, to close a gap) and the Credentialing Committee determines that no deficiencies or concerns have been noted on the Medicare or State oversight review that would adversely affect quality, care, or member safety.

Re-credentialing Process. Healthy Blue re-credentials providers no less frequently than every 3 years. The re-credentialing process begins when our credentialing database flags a provider who is due for re-credentialing. Our credentialing partner then checks the CAQH site for the provider's credentialing application. If the application has expired, we will ask the provider to update it. If the application is current, we download it to begin the review for completeness. Our credentialing partner follows the same process for obtaining information as occurs for initial credentialing, outlined above. If the application is complete, our credentialing partner queries the federal excluded provider databases to determine whether the provider has been recently excluded. Of note, we check these databases monthly and would have immediately terminated any provider who had previously appeared on the exclusion list. Our credentialing partner verifies credentials that may have changed since initial credentialing, such as licensure; certifications; health status; and performance, including complaints, malpractice experience, and loss of hospital privileges. They review reports from the Special Investigations Unit and other internal departments that may reflect on the provider's professional conduct and competence. We notify the provider of our re-credentialing decision only if it is adverse. For organizations, agencies, and facilities, where CAQH does not apply, we verify via accreditation or CMS survey, or we conduct a site visit, along with verifying the licensure. In 2021, we re-credentialed 419 contracted providers within 36 months.

Delegating Credentialing. Healthy Blue may delegate credentialing and re-credentialing functions to delegated entities. Delegated credentialing reduces the administrative burden for providers and, where feasible, is more efficient for all parties. Delegates may credential the following types of providers, including provider groups that meet specific eligibility requirements (based on size, experience, infrastructure, and professional liability insurance): pharmacy providers; medical group practices; hospital-based physician groups; and physician and physician-hospital organizations. The Credentialing department works closely with our Credentialing Committee, Vendor Oversight Committees, Medical Director, and QM team when evaluating delegates and determining ongoing compliance requirements. Delegates must:

- Meet or exceed all company and associated health plan requirements
- Meet or exceed all NCQA standards
- Meet or exceed all CMS regulations
- Comply with all applicable HIPAA requirements in accordance with business associate regulations

If Healthy Blue delegates credentialing and re-credentialing, the delegated entities must perform these functions according to our credentialing policies and procedures, which we embed in their contract. Healthy Blue retains final approval or denial for every provider participating within the delegated group.

Healthy Blue monitors credentialing performance through a Tableau-based Credentialing Inventory Report. This report allows the Credentialing team to track applications as they move through the credentialing process. It provides Healthy Blue with a quick snapshot and allows staff to drill down into the providers. In this way, no provider goes beyond 10 days without knowing the reasons.

Ensuring That Providers Are Enrolled in Medicaid and Have a Valid Identification Number

Healthy Blue checks provider Medicaid enrollment, including a valid identification number, against the Provider Network file when the provider submits their application, when credentialing is complete, and before allowing the provider to submit and be reimbursed for claims. If at the end point the provider is still not enrolled in Medicaid, we send a notification indicating that Healthy Blue cannot complete the credentialing process until they have enrolled with Medicaid. The notification contains information about how to enroll with Medicaid. We also provide information instructing providers on how to enroll in Medicaid and obtain a Medicaid ID, including a hotlink to DHHS's Provider Screening and Enrollment page.

Searches to Identify Excluded Providers and People Convicted of Crimes

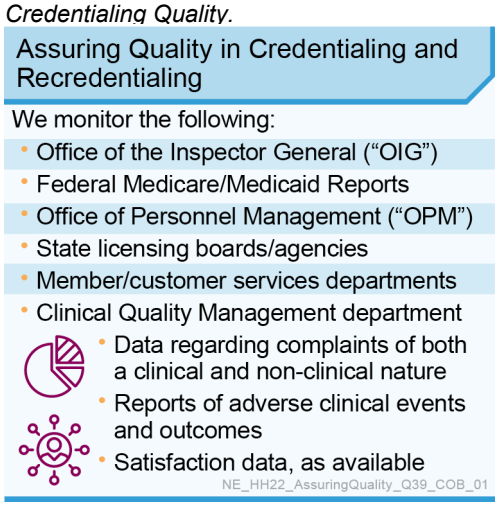
Our Credentialing team has established processes to assure that Healthy Blue, our subcontractors, and our network providers comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. Credentialing monitors in-scope providers against Licensure OIG, federal Medicare and Medicaid reports, Office of Personnel Management, and state licensing boards and agencies. If these sources identify a network provider or facility, we use formal criteria to assess the appropriate response, which may include review by the Credentialing Committee Chair, review by the Medical Director, referral to the Credentialing Committee, or termination from the network. We report providers to the appropriate authorities as required by law. If a provider's license is suspended or terminated, they are no longer eligible to participate in our network, and we terminate them immediately. We add providers terminated for sanctions and license issues to the Adverse Provider Action Report for tracking and reporting. If we do not renew a provider's network status, they may file an appeal within 30 calendar days of notification.

Using Quality and Utilization Measures in the Credentialing Process

The Healthy Blue Credentialing department performs ongoing quality and performance monitoring to help assure continued compliance with credentialing standards and to look for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing department reviews periodic listings and reports within 30 calendar days of the time they are made available from the various sources illustrated in Figure V.I.39-1.

Continuous Quality Improvement of Our Credentialing and Re-credentialing Process. Healthy Blue continually refines our processes to enroll providers into and retain providers in our network as quickly as possible. To accomplish this, we use national best practices as well as lessons learned in Nebraska and our affiliate markets. For example, one best practice is using DPE, described above, which allows providers to maintain a single CAQH profile for submission to multiple organizations, eliminating duplicative paperwork for providers.

Figure V.I.39-1. Healthy Blue Assures Credentialing Quality.



Experience with Centralized Credentialing

In compliance with DHHS requirements, Healthy Blue supports a centralized model for provider enrollment and credentialing to ease provider administrative burden. We will work with other contracted MCOs to procure a Central Credentialing Verification Subcontractor to begin services within 1 year of the MCO contract start date. In supporting this procurement, we can use the experience and expertise of our affiliate health plans that have implemented centralized provider enrollment and credentialing processes in supporting implementation in Nebraska. Our experience with centralized provider enrollment and credentialing systems dates to 2012, when our Georgia affiliate partnered with the state to develop a centralized credentialing portal and repository, and then assisted in the transition to a Credentials Verification Organization (CVO) model. Since then, our Texas affiliate successfully worked with the state to transition to a CVO; our Louisiana affiliate is currently collaborating with its state partner in its transition to a CVO model; and we successfully implemented operations in North Carolina, which uses a CVO model. To successfully implement a centralized model for provider enrollment and credentialing, we recommend the following approach:

- Establish a collaborative workgroup with all MCOs to create singular process
- Develop a comprehensive communication plan/training plan that includes statewide road shows to educate the provider community
- Stagger the integration of provider types into a centralized process to minimize provider-member abrasion

We will fully comply with all rules, regulations, and policies DHHS has established for any new centralized model. This compliance includes accepting DHHS enrollment and credentialing determinations as final. In addition, we will not require providers to submit supplemental information or meet additional credentialing requirements.

No. 40

Process for Maintaining Provider File with Information Sufficient to Support Provider Payment

Healthy Blue maintains standard practices for maintaining provider files that contain current information. We built our highly configurable Management Information System (MIS) off of a managed Medicaid model and the experience of our parent company in supporting Medicaid managed care programs in 26 markets, including Nebraska. We have the processes and IT systems in place to support fast provider payment, with an ***average turnaround time (TAT) from claims submission to payment of [redacted] days in the first and second quarters of 2022***.

As a quality check, our MIS contains rules that prevent us from moving a provider to active status without having all the necessary data to meet all pay claims and produce 1099s. We have processes in place to assure we only pay providers who are enrolled in the Nebraska Medicaid program, as well as provide a provider file that includes provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information, and any other data as required by MLTC and in a format specified by MLTC.

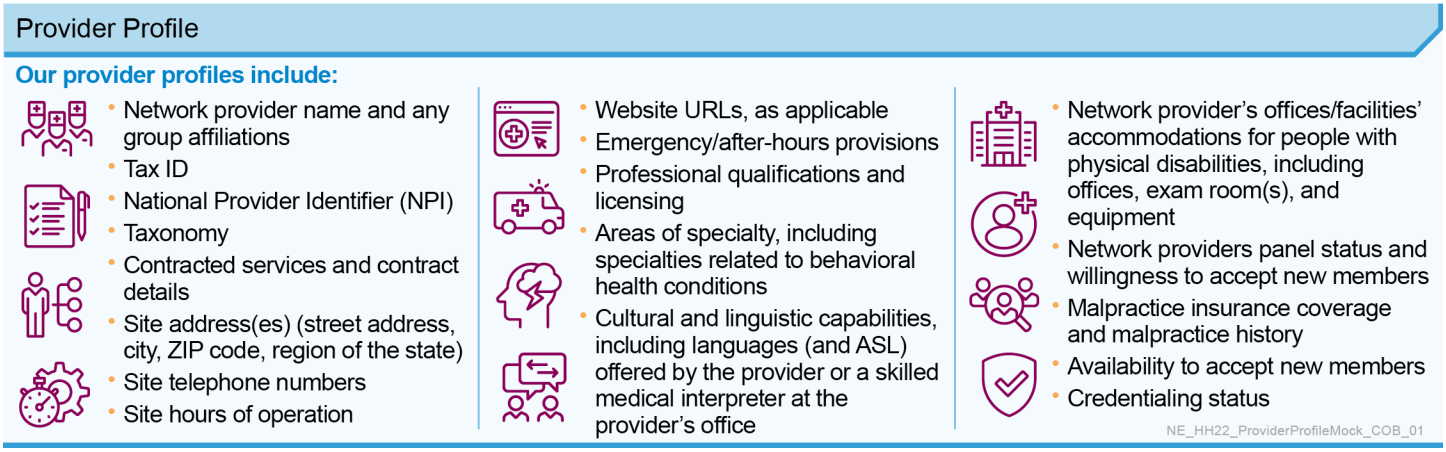
When Healthy Blue contracts with a provider, we load provider data into Facets to enable provider payment. Facets, TriZetto's industry-leading, core-administration and claims platform, serves as the primary source for Healthy Blue's provider, member (including enrollment and eligibility), service authorizations, claims processing, and grievances and appeals data. Facets is fully configurable, with business rules that guide claims payments, authorization and reporting requirements, and benefit limits.

We maintain a single, unique provider file that includes:

- A signed attestation
- A copy of the provider's current license issued by the State
- Valid DEA or Controlled Dangerous Substances certificate
- Proof or cover page of malpractice insurance (copy of certificate or cover page)
- Additional information specified by MLTC

We illustrate the data elements contained in our Provider Profile in Figure V.I.40-1.

Figure V.I.40-1. The Healthy Blue Provider Profile Contains All Data Required by MLTC.



We fully understand that MLTC will not reimburse for services rendered by any provider that is excluded or debarred from participation by Medicare, Medicaid, or the Office of the Inspector General (OIG), including any other states' Medicaid or CHIP program, except for emergency services. Our Credentialing team has established processes to assure that Healthy Blue, our subcontractors, and our network providers comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening (covered in detail in Question 39). Credentialing monitors in-scope providers against the following sources:

- Licensure Office of the Inspector General (OIG)
- Federal Medicare/Medicaid Reports
- Office of Personnel Management (OPM)
- State licensing boards/agencies

If we identify a network provider or facility utilizing these sources, we use formal criteria to assess the appropriate response, which may include review by the chair of the Credentialing Committee, review by the Chief Medical Officer, referral to the Credentialing Committee, or termination from the network. When appropriate, we report providers to the appropriate authorities as required by law. If a provider's license is suspended or terminated, they are no longer eligible to participate in our network, and we terminate them immediately. We add providers terminated for sanctions and license issues to the Adverse Action Report for tracking and reporting. If we do not renew a network provider's status, they may file an appeal within 30 calendar days of notification. Once we credential a provider, we check the above databases monthly and immediately terminate any provider who had previously appeared on the exclusion list.

Ongoing Maintenance of the Provider File. We perform ongoing maintenance of the provider file and assure the provider file is current through multiple methods. For example, we confirm demographic and other provider data when the provider calls our call center, meets with our Provider Experience team, requests an update, or updates their file directly through our secure provider portal (Availity).

As part of our continuous quality improvement efforts, Healthy Blue has replaced its current internal provider demographic management system with a new Strategic Provider System (SPS). This investment in advanced technology significantly improves provider data accuracy and transparency, enhancing the overall provider experience. New system features strengthen our ability to match submitted claims for more accurate pricing and processing. In the second phase of this initiative, we will integrate the SPS with Availity's Provider Data Management (PDM) functionality. This single, easy-to-use portal will allow providers to view, maintain, update, and attest to the accuracy of provider demographic information for Healthy Blue, resulting in even greater provider file integrity. The updated provider portal will enable providers to complete required verifications online via a simplified quick verification procedure — eliminating the need to fax, email, or use separate online forms. This service enhances the way providers send Healthy Blue demographic updates.

Issuance IRS 1099 Forms

Healthy Blue utilizes a centralized tax information reporting solution that can process of millions of forms, proactively validate information accuracy, and react to IRS changes almost instantaneously. Our on-demand, centralized platform allows us to manage organizational units, tax forms, and corrections in one place. Healthy Blue issues IRS 1099 forms for reportable payments made to payees that exceed $600 in a calendar year. We mail the payee a recipient copy of the 1099 form by January 31st of each year and provide an electronic filing to the IRS by March 31st of each year. We will also issue the appropriate type of 1099 form for each payee for which backup withholding tax was imposed, even if the reportable payments were less than $600 in a calendar year.

Healthy Blue Meets All Federal, State, and MLTC Reporting Requirements

Healthy Blue complies with all federal and State reporting requirements in maintaining provider files to support provider payment. Our MIS and reporting processes support seamless operation of all managed care functions and to produce timely and accurate regulatory and ad hoc reports in the formats required by MLTC. All provider data flows into our data warehouse, which we have optimized to support data analytics and ad hoc and regulatory reporting as required by CMS and MLTC, as well as internal reporting requirements, and it can easily be modified and expanded to meet new reporting requirements.

Assuring We Identify Excluded Providers

Healthy Blue has established processes to assure that Healthy Blue, our subcontractors, and our network providers comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. We do not contract with providers (including owners or operators) who the federal government or the Nebraska Medicaid program has excluded for fraud or abuse.

To meet NCQA CR-5 and Federal Requirement 42 CFR 455.436 related to ongoing federal and state monitoring, including OIG, General Service Administration (GSA) System for Award Management (SAM), State Licensure and Debarment, as well as any Nebraska-specific requirements, the Healthy Blue Program Data Integrity (PI) unit reviews participating and non-participating providers (as indicated within our claims payment system) monthly. This includes a review of both federal and State sites to assure that our provider network and on-par providers are eligible to receive payment for services rendered for Medicaid, Medicare, and other governmental programs. This includes:

- Confirming the identity and determining the exclusion status of providers and subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider, our organization, or subcontractor through routine checks of federal databases
- Checking the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Government Services Agency Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe
- Consulting appropriate databases to confirm identity upon enrollment and reenrollment
- Checking the LEIE and EPLS no less frequently than monthly
- Reviewing our Medicare network providers against the Government Business Administrator's (GBA) listings of Medicare opt-out providers (BBA of 1997, Section 4507)

If we identify a provider as excluded, we include them on a monthly exclusion report (which we provide to MLTC) and immediately terminate them from our network and deem them non-payable in our systems.

No. 41

Our Approach to Supporting Providers Assures Their Effective and Efficient Delivery of Covered Services

Provider Promise

As an MCO delivering the Nebraska Health Heritage services for more than five years, we have a history of partnering with providers to provide timely access to high-quality care, effectively manage costs, and meet local population health needs. We work with providers to improve administrative efficiencies through collaboration with our Provider Experience team; the use of our website, provider portal, and other strategies identified through committee participation; and on-site visits. Since establishing our network, we have expanded our provider and community partnerships and deployed innovations, such as telehealth and value-based purchasing (VBP) programs, creating new opportunities for increased access to services and resources for members. Our systematic and meaningful outreach engagement with providers and other stakeholders is key to our approach. We act on the feedback we receive to continually improve our program to make it easy for providers to care for members.

Our Provider Promise, to simplify health care so providers can focus on health, underpins our approach to our provider services program. Our Provider Advisory Committee (PAC) provides the organizational infrastructure for our provider collaborations. We have established policies and procedures (P&Ps), built on our Nebraska experience and best practices gleaned from our affiliates operating in 25 additional markets. Our P&Ps assure our provider services program meets or exceeds industry standards and that we fully support our provider community.

Healthy Blue's Provider Services Team Offers Providers Enhanced Supports

Our Provider Services Organization (PSO) is composed of specialized teams who collaborate with providers to implement our Provider Promise, as illustrated in Table V.J.41.1, and described more fully in the following text.

Table V.J.41-1. Healthy Blue's Provider Services Organization Is Dedicated to Supporting Providers.

PSO Function	Roles and Responsibilities
Enterprise National Contracting	▪ Enrolls ancillary providers leveraging enterprise contracts and specializes in negotiating transplant single-case agreements and letters of agreement ▪ Manages relationships for provider contracting, provider experience, and recruitment for national and ancillary networks while executing cost of care actions ▪ Focuses on driving strategic solutions, collaboration, and engagement while leading national contracting efforts that align health care management priorities
Network Management	▪ Locally based employees responsible for supporting providers throughout contracting process ▪ Negotiates terms and conditions of provider contract with providers and provider groups ▪ Recruits new providers into the network ▪ Recruits and enrolls providers into the portfolio of VBPs ▪ Assists with credentialing submission and loading process for existing providers who are not considered delegated ▪ Includes specialized consultants to work with providers to incentivize them through innovative ways and their contracts to meet the network gaps in Nebraska's many rural counties
Provider Experience	▪ Locally based Provider Experience Representatives support providers with education, training, and resolving operational issues or concerns ▪ Works with internal workgroups to help alleviate administrative burdens and improve processes for providers ▪ Includes a Tribal Liaison to collaboratively work with our providers who work with tribal populations that face disproportionate challenges with access to care
Provider Network Liaison	▪ Works collaboratively with the PAC to establish the process for responding to provider concerns ▪ Develops provider training in response to identified needs or changes in protocols, processes, and forms ▪ Enhances our MCO-provider communication strategies
Provider Claims Educator	▪ Educates in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available Healthy Blue resources, such as provider handbooks, websites, provider training materials, and fee schedules ▪ Communicates frequently with providers to assure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices ▪ Works with the call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements
[redacted]	[redacted]
Practice Transformation Consultant	▪ Collaborates with providers to make improvements in areas such as timely patient access, quality of chronic and preventive care, effective use of electronic medical records, patient centeredness, cultural competence, and team-based service delivery ▪ Helps clinicians and staff members develop the capacity for sustained change and improvement ▪ Specialized consultants focus on behavioral health (BH) and OB

At the heart of our PSO are our locally based Provider Experience Representatives. Upon joining our network, we send providers a welcome letter that contains critical onboarding information, including registration details for completing our new provider orientation. We assign each provider a dedicated, local ***Provider Experience Representative***, who schedules an initial meeting in which they welcome the provider to the Healthy Blue network, provide orientation based on the provider's preference, and work with the provider to establish ongoing regular interactions. Our Provider Experience Representatives are highly seasoned professionals responsible for cultivating and maintaining meaningful relationships with providers and serving as the provider's consistent primary point of contact. We train them to support providers on everything from training and operational support to claims submission and clinical practice transformation. They also work proactively with providers to identify trainings, education, and other opportunities of benefit to each provider.

To meet each provider's specific needs, we base Provider Experience Representative assignments on a variety of provider characteristics. Some examples are setting (for example, rural or urban), provider type or specialty (for example, hospital, Federally Qualified Health Center [FQHC], Rural Health Clinic [RHC]), provider panel size, and provider VBP program participation and maturity.

Provider Experience Representatives develop relationships with providers located in their coverage area through activities such as:

- **Proactive Education and Outreach.** Provider Experience Representatives deliver initial and ongoing education and training customized to the specific needs of each provider. We monitor performance data, such as claims denials, provider services call center interactions, and complaints to identify trends or patterns that are indicative of the need for additional provider training. They also inform providers of opportunities to attend webinars for continuing medical education credit on topics such as social determinants of health (SDOH), chronic condition management, health literacy, cultural competence, risk adjustment, and health equity.
- **Regular Meetings.** While we have general meeting frequency goals based on provider type, we also know there is no one-size-fits-all approach to provider support. Provider Experience Representatives work with providers to design a meeting schedule that meets their needs. They also adjust the meeting schedule on an ongoing basis to make sure providers are receiving the right level of support. Meetings can be in person, virtual, or a combination of both depending on provider preference.
- **Proactive and Ongoing Technical Assistance.** Provider Experience Representatives empower providers to succeed by proactively contacting them if we identify claims submission errors through ongoing claims review, notifying them when their recredentialing date is approaching, and providing updates on upcoming Medicaid policy changes. Provider Experience Representatives also meet regularly with our Claims Administrator to make sure they are proactively identifying and addressing any issues with claims submissions and any process updates to providers.
- **Prompt Response Times.** In addition to regularly scheduled meetings, providers can call or email their Provider Experience Representatives directly or request information via the provider website.

We expect each Provider Experience Representative to meet or exceed Healthy Blue service standards, including responding to provider requests within 24 to 48 business hours. To assure our Provider Experience Representatives are providing exemplary service and meaningful content during service interactions, we deploy a post-visit survey to solicit provider feedback and improvement recommendations. We also log all provider contacts, including email, in our Provider Relationship Management system. This allows us to monitor reports monthly and to stay abreast of adherence to service standards on a regular basis. This also provides ready access to providers to our posted notifications and policy changes in adherence to the minimum 45-day advance notice requirements.

In collaboration with utilization management (UM), we will be implementing a Gold Card program with our shared savings VBP providers. We will work with our largest VBP provider to identify a list of professional, ancillary, and facility codes that will not require prior authorization (PA) to be submitted by our Gold Card providers to perform the service. Through this program, we are relieving our Gold Card providers of the administrative burden of requesting authorization to provide certain types of care.

Healthy Blue Provider Experience Model Enhancement. Because every provider is unique, we tailor our service model to give providers the right level of support and engagement without creating additional administrative work. For example, when our larger and more specialized providers indicated a need for more tailored support, we responded by developing and deploying more focused Provider Experience staff. These enhanced staff collaborate with Provider Experience Representatives to offer larger and specialized providers (for example, FQHCs, RHCs, rural and frontier providers) additional levels of support, such as more frequent on-site meetings, proactive claims report monitoring, and claims dispute escalation. These staff have experience with and in-depth knowledge about these providers' needs. Providers can contact these support staff directly or through their Provider Experience Representatives.

Our Provider Handbook Offers a Resource to Providers

Our MLTC-approved provider handbook is a comprehensive and user-friendly resource to inform our network providers of program guidelines and requirements, covered services for members, provider roles and responsibilities, contractual information, and various requirements under state and federal law. We tailor the provider handbook to the unique needs of our Nebraska providers and MLTC contractual requirements. The handbook incorporates MLTC's Health Heritage priorities as well as feedback from our local stakeholders. We use established P&Ps to develop and maintain a medically accurate, compliant provider handbook, which undergoes a rigorous internal review by relevant subject matter experts, including members of our Quality, Clinical, Operations, Provider Services, and Compliance teams. These experts review the handbook content and provide feedback and suggestions for improvement at least biannually and obtain MLTC approval before implementation. With every update, we distribute periodic notices and amended portions to providers through a clear change process. In compliance with the SOW, we will submit a copy of the provider training handbook and training schedule to MLTC for review and approval a minimum of 120 calendar days prior to the Contract Start Date. We will submit any changes to the handbook to MLTC a minimum 45 calendar days prior to scheduled changes and dissemination of such changes.

As a companion to the provider handbook, we offer a ***quick reference guide*** for providers. A condensed version of the provider handbook, this guide provides the most vital and frequently used information providers need in a user-

Healthy Blue's Quick Reference Guide

Our quick reference guide provides essential, easy-to-find information, such as:

- Healthy Blue contact information
- Prior authorization (with specific information about specialty care and situations such as imaging, EPSDT, hospital admission, OB, and pharmacy)
- Our service partners
- Provider Experience program overview and contact information
- Claims services
- Payment disputes
- Grievance and appeals
- Care management
- Quality management

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friendly, accessible format. The quick reference guide provides critical information to support providers while they are delivering services in the community. Providers can access the reference guide and our full provider handbook 24/7/365 on our provider website.

Our Formal Committees Assure Engagement with the Provider Community

We obtain regular provider feedback on our processes and procedures through our PAC. ***Since 2017, we have overseen and facilitated an engaged and active Healthy Blue PAC.*** Our Chief Medical Officer (CMO) chairs our quarterly PAC meetings with facilitation support from our National Accreditation Consultant. Our PAC is our primary strategy to promote ongoing and seamless communication with our network providers, as it gives them a direct voice in developing and monitoring clinical policies and operational issues. Our PAC also gives providers the opportunity to offer input regarding potential innovations that could improve health outcomes for our members. Through consistent collaboration with the PAC, our Provider Network Liaison establishes a productive process for soliciting and responding to provider concerns, continually improving our provider education and training programs, and enhancing our communication strategies. We report all PAC feedback and input to the Quality Assessment and Performance Improvement Committee, which is responsible for oversight of all quality for Healthy Blue**.**

In compliance with SOW V.M.4., our PAC is composed of Nebraska providers, representing multiple provider types and specialties and include the following members: Dr. Jeffery Snell, PhD, Neuropsychologist; Dr. Sharon Hammer, MD, Psychiatrist; Dr. Scott Micek, DC, Chiropractor; Dr. Scott Wilson, MD, Family Practice; Mary Walsh-Sterup, OTR/L, CHT, Occupational Therapist; Dr. Andjela Drinicic, MD, Endocrinology/DM/Metabolism Specialist; Dr. Rajesh Tampi, MBBS, DFAPA, MS, Psychiatrist; Dr. Sara Zachman MD, MPH; and Pamela Dickey, MPAS, PA-C, Family Medicine. Dr. Tampi was recently named Chair of the Department of Psychiatry at Creighton University, and Dr. Zachman has a faculty appointment at University of Nebraska Medical Center.

In addition to our PAC meetings, we will hold quarterly peer-to-peer discussions between providers and our Medical Directors to build a stronger partnership with providers, identify areas of improvement, solicit feedback on what is working well, and promote the efficient delivery of care for our members. Our Medical Director conducts ad hoc discussions with peers through the Nebraska Psychiatric Society and the Nebraska Medical Association, as well as through meetings with providers to solve targeted BH issues.

We take our PAC's feedback seriously and use insights to enhance our programs and to make them meaningful for providers. Our Provider Network Liaison will work with our PAC members to make certain that meeting agendas include topics of their interest and priority. The liaison also develops and maintains positive relationships with our provider community through visits, communicating administrative and programmatic changes, and facilitating education. Our liaison serves as a knowledge and resource expert on the complex concerns and issues that affect provider satisfaction and will work with the PAC to address provider concerns. Provider training is a PAC standing agenda item. The Provider Network Liaison will engage our PAC in the development of provider training, including providing feedback on the training topic, delivery methods, and content.

In 2023, we will establish and convene a Rural Health Workgroup to discuss rural access to care and solicit solutions to challenges the providers face in delivering care in rural Nebraska. Our PAC will work closely with this workgroup and review their feedback and recommendations to assess where we can make improvements to assure Healthy Blue is responsive to the concerns of our rural providers.

Our team continually looks for ways to improve our programs and processes based on provider feedback. Recent examples of our enhancements initiated because of our PAC efforts include:

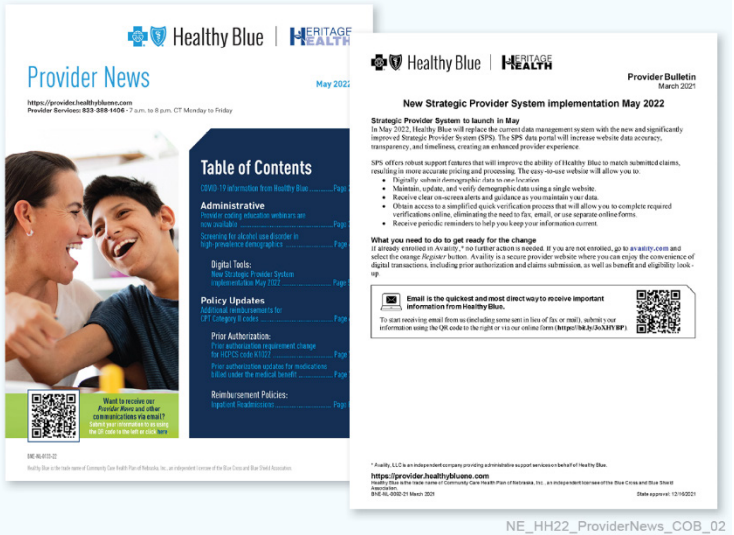
- **Streamlined Communications.** We received feedback from our providers that they were receiving too many lengthy communications from each of the health plans. To streamline communications, we created and distributed our monthly provider newsletter, which is a more condensed snapshot of the most relevant provider information.
- **Quick Responses.** Our providers told us that they wanted a faster way to get responses from us for questions related to claims and PA requests. As a result, providers registered for our secure portal through Availity can now use the new Provider Chat functionality to get immediate answers to these types of questions.

Our Provider Outreach Methods and Communication Channels Support Providers

Newsletters, Bulletins, and Online Sources. Our provider website is the central hub for provider communication, key program information, resource materials, and online functionality. It includes key contact information for our teams so providers can get in touch with us whenever they need. We feature our dental program information, including a link to its site, on our provider website to make it easy for providers to find. The website features tools that promote convenience and transparency while simplifying practice management. It allows us to disseminate information quickly and efficiently to providers, offering immediate access to important information and a connection to the tools and resources needed to deliver appropriate care. To make it easy for our providers to participate in our network, we make our provider website accessible and functional on mobile devices.

We educate providers about the resources available on our provider website through multiple modalities, including in-person Provider Services staff visits and at trade association meetings, new provider orientations, newsletters, workshops, Webex, and the provider handbook. These resources promote communication and convenience and support the complaint and resolution process. This includes links to online training, monthly provider bulletins and newsletters, and network

Sample Provider Outreach Methods: Provider Newsletter and Provider Bulletin



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e-updates that include important information on claims submission processes, pharmacy, BH, the PA process, and other items that are important to the provider community. We use our newsletters, provider bulletins, and emails to proactively reach providers with critical information, and we tailor the content and delivery based on provider need and feedback.

Our provider website includes a publicly accessible side and a HIPAA/HITECH secure portal deployed through ***Availity***. Availity is a robust, multi-payer portal that offers online functionality, such as claim submission and inquiry, claim dispute submission and tracking, and PA submission. Availity also gives providers access to Patient 360°SM, part of our centralized care management platform that shares and aggregates actionable member data across systems and organizations. The platform offers providers an easy-to-navigate dashboard with member-specific information to see care plans and assessments to reduce duplication, address unmet service needs, improve appropriate service utilization, and prevent unnecessary use of emergency services. The platform identifies missed opportunities for care, such as missed pharmacy refills, which prompt provider follow-up with the member to address changes or challenges. Providers can also use this tool to create and use customized reports to address their specific needs. ***Health Intech*** promotes effective, efficient, and collaborative care coordination — particularly for individuals with complex, high-risk needs. It connects the entire community of preferred support, facilitating communication, collaboration, and information-sharing among all stakeholders.

In addition to our online and print resources, we support our providers by offering telephonic access to Provider Services by calling (833) 388-1406 Monday to Friday 7 a.m. to 8 p.m. CT at our national contact centers. Providers who register for Availity can now use the new provider chat functionality to get immediate answers to their questions when they prefer not to make a phone call.

We Engage Our Providers Through Consistent and Systematic Outreach. Healthy Blue has numerous outreach strategies to engage our provider community. Our skilled Provider Experience team, Quality Management team, and Provider Claims Educator all collaborate to implement these strategies and assure that the lines of communication between Healthy Blue and our providers remain open. Such strategies include our provider townhall meetings, provider surveys, and provider listening sessions:

- **Provider Townhall Meetings.** Townhall meetings occur quarterly and give providers an opportunity to learn about topics such as authorization, credentialing, claims issues (such as claims dispute process and overpayment recovery and refunds), appointment availability requirements, and tools and resources available to providers. Our townhall meetings also include an open forum question and answer session to address provider questions in real time.
- **Provider Surveys.** We conduct annual surveys to question providers' understanding and gain critical feedback directly from providers on how we can improve. We solicit feedback on the effectiveness of our communication tools, including our provider handbook, remittance advice, care coordination between physical health and BH, training modules, and more. We conduct additional surveys with our providers on care management, UM, and Disease Management programs. These separate surveys for each program give us critical input on how the programs are helping our members and how we can improve them to drive better health outcomes. We also gain critical insights on methods to improve provider collaboration.
- **Ad Hoc Provider Surveys.** A recent addition to our provider feedback collection methods, providers can complete our ad hoc provider surveys anytime through our provider website and through a link in our staff's email signature lines. The survey allows us to understand provider experiences and identify areas of deficiency in real time and in between administering our yearly surveys.
- **Provider Listening Sessions.** As a part of our strategy, we will hold listening sessions with providers and provider associations to understand issues, including local access challenges and nuances within the state. We have conducted these sessions both in person and virtually to assure the greatest access and safety during the pandemic.

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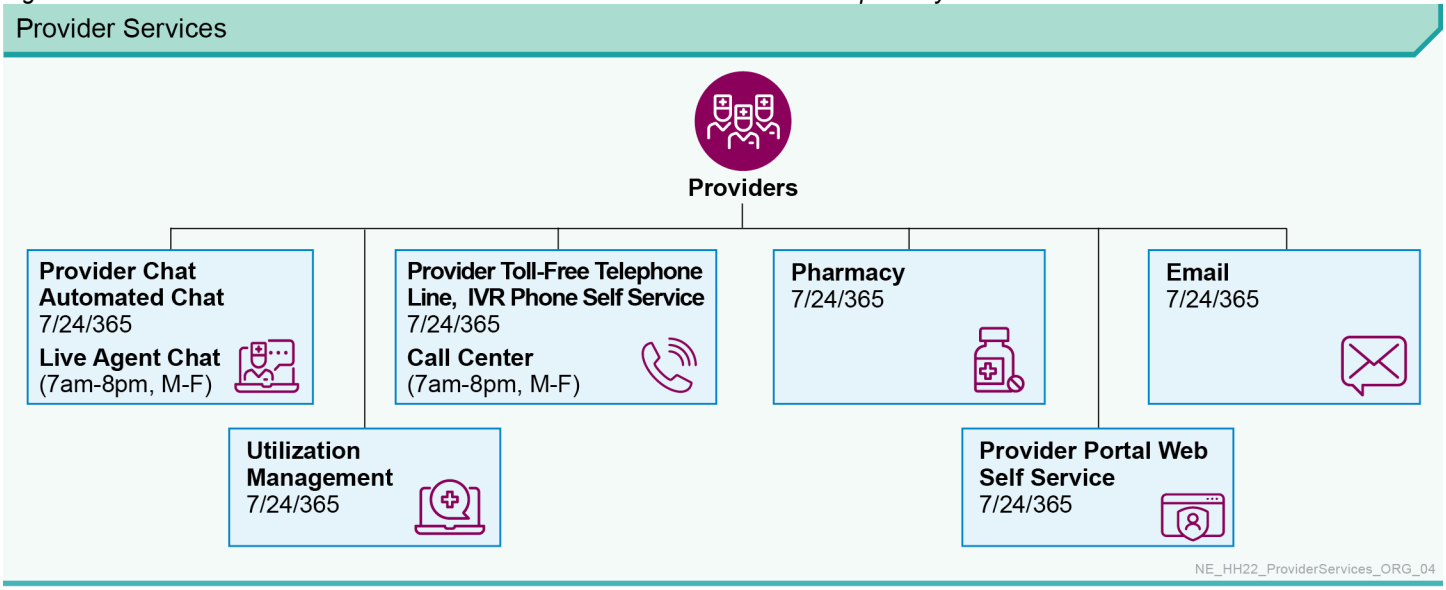
At Healthy Blue, we recognize that member access to care depends on having a robust provider network, which itself is only possible if providers have a good experience when working with us. As Figure V.R.42-1 shows, we have developed multiple channels through which providers can contact us including online provider chat, calling our provider help line and sending emails. To assure a consistently positive experience, all of our Provider Services Representatives (PSRs), whether ultimately assigned to chat, email response, or help line, receive the same training and have access to the same tools and information.

Figure V.R.42-1. Our Suite of Provider Communications Channels Provides Multiple Ways for Providers to Reach Us.



Provider Chat

Healthy Blue's provider chat function is made available through the Payer Spaces section of the Availity provider portal. Our provider chat function can address any inquiry that could be addressed with a call to our Provider Services team. First, the provider logs in to Availity and selects the market, then selects Payer Spaces and the plan. In Payer Spaces, the provider selects the "Chat with Payer" option. A pre-chat form will display to provide additional information needed to route the chat. Upon completion of the pre-chat form, providers are offered the opportunity to use the self-service option, through which they can inquire about claim status with payment or denial details, authorizations requirements or disposition, benefits and coverage, and eligibility confirmation. Throughout the interaction, a provider can request to transition to a Chat representative at any time. A post-chat survey appears at the end of the chat. [redacted] Live representatives are available 7:00 a.m. to 8:00 p.m. CT, Monday through Friday, and self-service capabilities are available 24/7.

Provider Portal

Our provider website includes a publicly accessible side and a HIPAA/HITECH secure portal deployed through Availity. Availity is a robust, multi-payer portal that offers online functionality such as claim submission and inquiry, claim dispute submission and tracking, and prior authorization submission. Availity also gives providers access to Patient 360°SM, part of our centralized care management platform, Health Intech, that shares and aggregates actionable member data across systems and organizations. The platform offers providers an easy-to-navigate dashboard with member-specific information to see care plans and assessments to reduce duplication, address unmet service needs, improve appropriate service utilization, and prevent unnecessary use of the emergency services. The platform identifies missed opportunities for care, such as missed pharmacy refills, which prompt provider follow-up with the member to address changes or challenges. Providers can also create and use customized reports to address their specific needs using this tool. Health Intech promotes effective, efficient, and collaborative care coordination — particularly for individuals with complex, high-risk needs. It connects the entire community of preferred support, facilitating communication, collaboration, and information-sharing among all stakeholders.

Provider Toll-free Telephone Line

Healthy Blue's provider toll-free telephone line offers comprehensive, personalized assistance to our providers who have questions, concerns, or complaints. Timely and accurate responses by the provider helpline are essential to building a collaborative relationship with our providers. Since January 2021, [redacted]

Meeting providers' needs requires a specialized approach and training. Our provider toll-free telephone line is the central point of contact for provider calls regarding eligibility, benefits, authorization, and the resolution of claims issues. Our PSRs are well-versed in Nebraska's Medicaid program requirements and benefits as well as claims processing. [redacted]

All other hours are covered by voicemail, Electronic Prior Authorization (ePA) and fax. We have a voicemail for after-hours calls for all other markets/LOBs that is checked first thing in the morning. The prescriber can submit via ePA 24/7 or submit a fax 24/7.

When providers call the provider toll-free telephone line, they are prompted to enter their NPI. The call then enters the main menu, which includes the following options: member status, precertification, claims, care management, website support, pharmacy services, or direct transfer to a PSR. The provider toll-free telephone line also has claims-trained representatives who can adjust claims over the phone. When a provider calls and indicates they are calling about a claim and require assistance beyond the self-service options offered, they are transferred directly to claims-trained representatives.

Our powerful customer service platform enables our PSRs to respond efficiently and effectively to inquiries and requests by integrating information from multiple back-end systems onto a single-screen view. The integrated desktop rapidly accesses and displays data related to the member's benefits, assigned PCP, service utilization and claims history, enrollment, authorizations, and other health insurance coverage and is tailored to specific MLTC programs and service areas. The PSR can also view a list of a provider's appeals by member and the processing status of each appeal.

Provider Toll-free Telephone Line Staffing

Healthy Blue's provider toll-free telephone line is staffed with personnel trained to accurately address provider questions, concerns, and complaints. Live PSRs are available 7:00 a.m. to 8:00 p.m. CST, Monday through Friday. Providers seeking information and assistance after normal business hours can select from a menu that offers points of self-service, depending on the caller's needs and preferences. Providers can also access both licensed utilization review nurses and non-clinical prior authorization staff for assistance with prior authorization. Healthy Blue's provider toll-free telephone line is available every business day except for the State holidays permitted by MLTC, as listed in the SOW.

Our PSRs are employees of Healthy Blue and are trained specifically on the Nebraska Medicaid Program, Nebraska Medicaid Contract requirements, and unique State geography and needs. [redacted] Our staff offers providers a single point of contact to simplify services with automated self-service after hours. Our PSRs are scheduled by workforce management using the following process:

We develop a forecast of monthly call volumes and average handle times for provider calls using:

- Membership projections
- Comparisons to historical contact rates and call lengths from a combination of markets presumed similar for various factors
- Factors applied for initial, short-term, often extreme variances at program go-live, with ramp patterns/paths to eventual "normal" expected levels
- Seasonal variations

These forecasts establish staffing requirements and hiring/training plans. The drivers include:

- Calls
- Average handle time
- Service level requirements
- Planned maximum occupancy
- Shrinkage — activities/events/time off the phone lines or not at work, including time off, absences, leave(s), paid breaks, meetings, training, coaching, and unplanned/adherence assumptions
- A small risk/volatility/schedule effectiveness factor to account for natural volatility across like days and intervals, peaks first-of-the-month for member, and end-of-the-month for provider
- Assumed attrition as well as loans/borrows/promotions
- Hiring plan/schedule

Forecasts are developed for each half-hourly interval, by day, and ongoing. From these, employee schedules are created and maintained, and time off and off-phone activities are planned. Independent processes are instituted at regular intervals to review and adjust forecasts as relates to changes in membership, daily and interval actuals and patterns, planned ramp from go-live to "normal," and seasonal factors.

To adjust our staffing for different time periods in each month (heavy at the end for providers), and for peak days during each week (Tuesdays for providers), we vary our employee schedules by day of week and vary our planned time off and off-phone activities to preserve more resources for heavy periods and allow more off phones for lighter periods. We can also call on Operations Expert and Quality resources as needed.

Our Workforce Management team monitors call volumes in near real time. If a workload or staffing variance occurs, additional reps are added to the queue, providing the necessary staff to meet the actual call volume. This is monitored at all times during the day for current status and accumulated service results and workload variances are reported at regular intervals throughout each day. Even though planned call routing from primary to secondary groups is automated, we can manually adjust them when needed.

Monitoring Quality and Accuracy of Information Provided to Providers

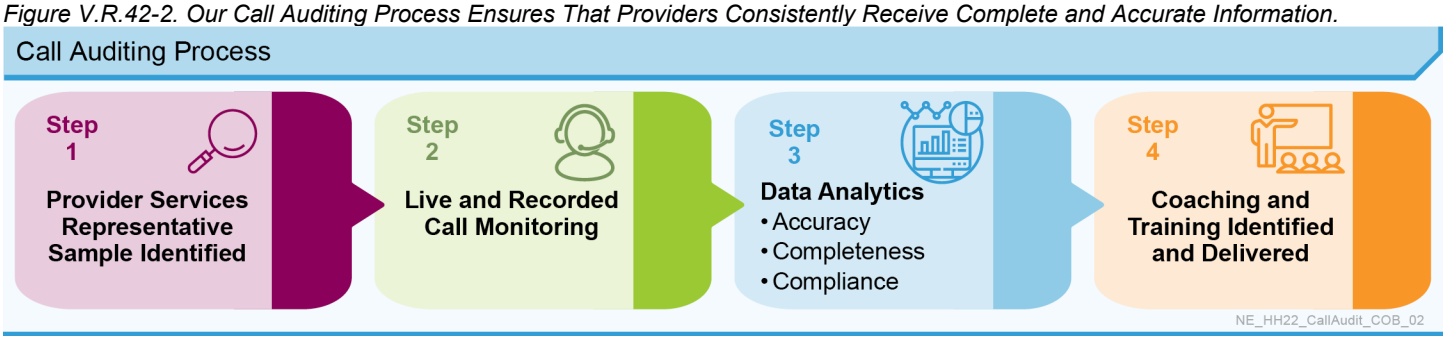
We monitor and evaluate the quality of service and accuracy of information delivered to providers through call monitoring and documentation reviews of PSRs. All callers hear a message informing them that their call may be monitored for quality control purposes. The recordings are used to provide feedback and coaching to individual employees and give us opportunities to improve performance, assess the accuracy of information provided, and evaluate the quality of the interaction between a representative and a provider. Call monitoring includes the following:

- Silent monitoring
- Recorded calls
- Side-by-side monitoring

Call monitoring for experienced PSRs is performed randomly throughout the month. Quality evaluations for newly hired employees completing training are conducted more frequently, and the results are used immediately as coaching opportunities during the first two months on the phone. The quality audit evaluates performance in multiple areas related to program knowledge and a services-oriented approach to call handling. We tabulate aggregate and individual performance information, make it available monthly to the Helpline

Management team, and use it to develop training for our current staff as well as to improve our new hire training program. Figure V.R.42-2 shows our call auditing process. [redacted]

Figure V.R.42-2. Our Call Auditing Process Ensures That Providers Consistently Receive Complete and Accurate Information.



Monitoring and Reporting Provider Calls and Inquiries

We currently comply with all MLTC requirements for monitoring and reporting numbers and types of provider calls and inquiries. We use multiple call status reports at a variety of frequencies, ranging from every 15 minutes to quarterly, to monitor our performance and compliance with performance standards. Our reports show trends for call volume, average speed of answer, length of call, and abandonment rate. We evaluate existing processes for our provider toll-free telephone line and make necessary adjustments to improve the quality of service offered by our representatives. We consistently meet or exceed all service levels and requirements.

We maintain operating protocols that promote consistent attainment of our service standards, including real-time monitoring of our call-handling performance. Our Workforce Management team monitors our provider toll-free telephone line's telephony metrics using a variety of technology tools and real-time reports. When call volume increases beyond the capacity of our scheduled representatives to respond or in the case of facility or system outages, we can expand the call answering queue to include designated backup representatives in our organization's other helpline locations. Our ability to move calls between our multiple helplines enables us to react quickly during emergencies or natural disasters.

Our provider toll-free telephone line data is at the core of the day-to-day management of the helpline. It is used to:

- Forecast and schedule, and for real-time management and root cause analysis, to identify and lock in capacity required to meet demands efficiently
- Allow us to accurately predict future volume and handle staff shrinkage by queue and skill type
- Design and manage an efficient staff scheduling system
- Plan and schedule out-of-seat activities (for example, trainings and team meetings) around demand spikes
- Monitor demand and staffing in real time and flex workforce accordingly
- Measure performance in each discipline with a transparent set of key metrics and targets
- Inform us where we may have training or refresher training needs

If there is a material difference between the volume of calls coming in and the forecasted number, PSRs are added or removed from the queue. When a representative is removed from the queue, they are released to complete assigned training. When call volume is higher than expected, leadership pulls data related to the call types and reaches out to our Provider Experience team as necessary to gain a better understanding of what is driving the calls and what can be done to proactively address the issue (for example, notification on the website, fax blast, or outreach from Provider Experience staff).

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Healthy Blue Provider Education and Training Program

Healthy Blue's continued collaboration and partnership with Nebraska providers is a foundational element of our strategy to assure equitable, whole-person care to members and improve population health. We believe provider education and training is essential to the success of any member experience endeavor and is particularly important when providers join the Medicaid program. This is part of our Provider Promise to achieve health communities through our resolute commitment to simplify health care so that providers can focus on health. Our Provider Training Plan forms the foundation for our long-term, collaborative provider relationships, and our programs reflect lessons learned and best practices. We update our Provider Training Plan at least annually, and upon any significant changes to federal, State, or Plan requirements (for example, new billing requirements, trending issues, training needs identified by DHHS or Plan staff).

Provider Promise

We call our approach to provider collaboration our Provider Promise because we know that the best way to achieve healthy communities is through our resolute commitment to simplifying health care so providers can focus on delivering care. Healthy Blue's field-based staff, such as our Provider Experience Representatives, collaborate directly with providers in the very communities in which they live to assure our education and training programs meet their needs. We also have a dedicated Nebraska Provider Claims Educator position in compliance with State requirements.

Healthy Blue Medicaid Training Academy

We reflect our commitment to training in our Medicaid Training Academy (Academy). In line with our Provider Promise to simplify health care so providers can focus on their patients, Healthy Blue offers educational and training resources through the Academy that empower our Providers to provide high quality, culturally sensitive, and cost- effective care. The Academy reflects our commitment to delivering the right curriculum, at the right time, to empower providers to succeed. It serves as a hub for provider information, technical assistance, training, and curricula that begins with New Provider Orientation and continues with ongoing education opportunities and resources to reinforce learning. We ease administrative burden for providers by delivering Academy training and education via multiple modalities, including in-person sessions, workshops, webinars, customizable on-demand online training, free continuing medical education (CME), and digital offerings for provider convenience.

Providers can access the Academy 24/7/365 via both our Provider website and our secure Provider portal (Availity). The Academy serves as a hub for provider education and training resources and activities, including:

- **New Provider Orientation.** Through in-person, virtual, and recorded versions of provider orientation sessions, we make sure providers complete training within 30 days of joining our network. In 2022, we will also make Provider Pathways, described below, available to providers.
- **Individual Training.** Healthy Blue providers can always access specific individual training courses as needed.
- **Group Training.** We offer group training in several settings to provide targeted training upon significant changes to Healthy Blue program requirements or when we have added information to improve member outcomes, reduce provider administrative burden, or impact performance goals. Settings may include Town Halls, Lunch and Learns, Provider Forums and Workshops, and Association meetings.
- **On-Demand/Online Resources.** Providers and their staff can access information and participate in group and individual educational events from the comfort of their offices. Online resources include Toolkits (for example, the Cultural Competence Toolkit, CMS telehealth toolkit), the Provider Handbook, Provider Newsletter, and Online Bulletins and e-Updates.
- **Additional Provider Services & Outreach.** We outreach and engage providers through our Provider Experience Representatives in-person and virtually, and through fax blast notifications.

To identify specific provider training, education, and outreach needs, we engage and collaborate with DHHS as well as providers, provider associations, and other stakeholders. We also monitor trends, such as claim denials, by individual providers and provider groups and provide one-on-one or group trainings for providers experiencing persistent issues. Examples of Training and Resource materials available to our Providers include:

- Nebraska Provider Handbook
- Provider Quick Reference Guide
- Centers of Medical Excellence Transplant Operations Manual
- Healthy Blue FAQs
- Healthy Blue Policies & Procedures
- Nebraska Health Link Requirements
- Healthy Blue Medicaid coverage requirements for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Prior Authorization, and Preventive Health Screenings
- Got Transition® Family Toolkit
- EPSDT Toolkit
- MCH/EPSDT Coordinator and EPSDT Specialist to provide education
- Healthy Blue Provider Orientation
- Behavioral Health Provider Orientation
- Electronic Funds Transfer
- Interactive Care Reviewer
- Clinical Practice Standards & Utilization Management Programs
- Telehealth Toolkit for Providers
- Behavioral Health for PCPs
- Pharmacy Formulary
- Principles of Rehabilitation & Recovery from Mental Illness & Substance Use Disorder
- Trauma Informed Care
- Identification of Special Needs Members
- Appropriate Utilization of
- Emergency Department Services
- Care Management, Discharge Planning Requirements, Prevention, Disease and Population Health Management Programs

We advertise our Academy training program and continuing education unit (CEU) opportunities during New Provider Orientation, on our provider website, and in our provider handbook, newsletters, bulletins, and flyers.

Provider Pathways

Provider Pathways is our digital offering, scheduled to launch in Quarter 4 of 2022, This platform will provide an overview and access to Healthy Blue's most frequently used tools and resources for Medicaid providers. Provider Pathways allows providers to be in control of their learning experience, and determine the pace, timing that best meets their needs.

Utilization is trackable and reportable, allowing for a pull of training attestation to accommodate State reporting requirements and for providers to validate whether their staff have completed the required trainings. Offering orientations through several media allows provider practices, whether large or small, urban, or rural, the flexibility to choose the orientation method that works best for them. Training modules include information on the most frequently used provider tools and resources, including:

- Joining our Network
- Signing up for Availity
- Enrolling in electronic fund transfers and electronic remittance advice
- Checking Member eligibility and claim status
- Authorizations

Cultural Competency Training

Providers are key allies in reducing health disparities and promoting a culture of health equity. Our adherence to the highest standards of cultural competency and health equity starts with our recruitment strategy, assuring we have a diverse network to meet the cultural and linguistic needs of members. We will also promote access to culturally competent care through our innovative VBP programs, which will require that providers complete specific improvement activities to receive incentives, such as implicit bias training. We will also provide cultural competency training in our initial and ongoing provider orientations and will promote cultural competency during regular interactions with our providers, including in-person meetings, monthly newsletters, and through our provider handbook. We will provide toolkits, direct access to relevant training, and racial equity provider forums that promote cultural competency, described further below.

Caring for Diverse Populations Toolkit

We will offer providers a toolkit that helps identify the best way to communicate with diverse patients, find information on providing culturally competent care and services, how they can engage key community-based organizations to address social needs, and use interpreters for members with limited-English proficiency. This toolkit will assist network providers and their office staff while also serving as a resource to help reach national goals for reducing health disparities caused by lack of culturally or linguistically appropriate care. In addition to the toolkit, we will also provide a customized social determinants of health (SDOH) hot spotting platform to help providers identify social barriers that affect specific population conditions. We update the tool monthly to aggregate member data, including geographical density, claims data, chronic or behavioral health (BH) conditions, maternal health statuses, admission rates, and utilization rates to trend member experience. Hypertension and diabetes are chronic conditions that are key priorities for the Chronic Conditions Workgroup with the focus on African American, Hispanic, and Tribal Populations.

Continuing Medical Education Credits and Continuing Education Units

Providers can earn CME or Continuing Education Unit (CEU) credits through the Academy at no cost to them, in support of their ongoing development. CME and CEU courses include:

- Promoting Birth Equity
- Caring for Children with ADHD
- Equity in Asthma Care
- Creating LGBT-friendly Practice
- Reducing Health Care Stereotype Threat
- Medication Adherence
- Improving Patient Experience
- Breast Cancer Screening
- Health Equity/SDOH
- SDOH- How they Affect Primary Care
- Racial Equity Training
- Provider Coding Education
- CPT Changes & CPT Category II Codes: Improving Performance Quality
- Complete & Accurate Diagnosis Coding
- 2022 Coding Updates
- Understanding Risk Adjustment
- Building Integrated Medical Record Retrieval Processes
- HEDIS Quality Measures
- Behavioral Health HEDIS Measures
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Development Screenings
- Behavioral Health
- Cultural Competency
- Behavioral Health Substance Use Disorders
- CAT II
- Telehealth 2.0- Building a Sustainable Model
- Generic Prescribing Percentages

Among the most popular courses in 2021 were Telehealth, CPT Changes, and Complete and Accurate Diagnosis Coding. The feedback from network providers on Healthy blue CEU and CME courses has been overwhelmingly positive.

Racial Equity Provider Forums

Through our Academy providers can also sign up for our Racial Equity Series, which launched in 2020. The series promotes open discourse about trauma, racial injustice, and inequities that affect the health and well-being of the communities we serve. We invite our primary care providers (PCPs)/patient centered medical homes (PCMHs,) BH, and substance use disorder (SUD) providers to participate in quarterly virtual discussions with a diverse panel of respected mental health and health care professionals from across the nation that give providers the opportunity to gain a deeper understanding of the impact of racial trauma, share experiences, and learn about racial equity and allyship, to better support our members. We offer CME credits to forum participants at no cost, and all our providers have access to recordings through our Provider website.

Disability Accessibility and Equity

Partnering with leading advocacy voices from across the state and nation, we will offer resources and information about making service delivery settings accessible for people with disabilities. Recommended practices include setting up separate waiting rooms or quiet spaces for people to prevent sensory overload, assuring physical accessibility including exam tables and scales, allowing support workers or caregivers to accompany patients into the exam room, assuring that instructions are written in plain language and are clear, providing interpretation supports if necessary, using visual aids or communication boards for people who are non-verbal, and training office staff to be accommodating and welcoming. We offer comprehensive training through mydiversepatients.com.

Educating Providers About Specific Member Needs

We provide education, resources, and training to our providers about specific conditions and circumstances to assure we can meet the specialized needs of our members. We align members with chronic conditions or health circumstances with appropriate care management (CM) team resources who will offer member-specific education. The CM team resources support providers by sharing monthly stratification data to ensure providers are aware of changes in the member's condition to help guide appropriate interventions.

Care managers also share assessment results, treatment plan components, and referrals made on behalf of a member to keep providers informed about the services and supports the member is receiving. Care Managers share condition-specific materials with providers so they can reiterate self-management concepts with members and educate providers on the programs and services available that may supplement efforts to improve member outcomes, including digital solutions, value-adds, and telehealth kits for chronic condition management.

In addition to this CM support, all providers will also have a designated Nebraska-based Provider Experience Representative who will provide customized trainings based on the needs of each provider practice. They will also connect providers to a variety of resources, including evidence-based strategies, care protocols, and population health management interventions that help support our members with these conditions. We will also include relevant education in our monthly electronic newsletters, bulletins, web-based trainings, and our provider handbook. We also have more than 40 clinical practice guidelines on our provider website that supply condition-specific evidence-based approaches to support member treatment. We list additional resources that will supplement this approach to provider education in Table V.J.43-1.

Table V.J.43-1. Additional Resources to Assist Our Providers on Our Members' Specific Conditions and Circumstances.

Member Need	Support Staff	Training and Resources
(a) Perinatal Care	▪ Maternal Child Health (MCH)/EPSDT Coordinator will meet one-on-one providers to provide resources, education, and interventions available to support maternal and women's health	▪ OB-GYN Profile Reports will include provider performance data stratified by race and ethnicity to identify health disparities in the practice ▪ Training on digital CM solutions, including remote patient monitoring for high-risk pregnancy ▪ Financial and technical assistance to support costs associated with adopting the Centering Pregnancy group-based maternal care model
(b) Behavioral Health	▪ Care Delivery Transformation (CDT) Consultants will support collaboration between BH providers and physical health providers related to focused HEDIS and QPP, P4Q and HEDIS measures ▪ BH Clinical Director will provide education on BH policy and strategy ▪ BH Clinical Program Development Manager will serve as a provider education resource	▪ Access to a mental health education platform ▪ Toolkits for managing BH conditions, including ADHD, autism, trauma, and depression ▪ Training and tools that include evidenced-based practices (EBP) and clinical practice guidelines ▪ PHQ9 or CAGE questionnaires
(c) Substance Use Disorder	▪ CDT Consultants will support performance in SUD VBP programs ▪ BH Clinical Director will provide education on policy and strategy in our Medical Advisory Group ▪ BH Services team, along with Provider Experience team will provide education to BH providers	▪ Provider website will include trainings on MAT/opioid use and polypharmacy education ▪ SBIRT toolkit and incentives for screenings ▪ Access to MAT/SUD telehealth providers
(d) Chronic Conditions	▪ CDT Consultants will meet monthly with Providers to provide performance insight, education, and support closing care gaps for chronic conditions ▪ Diabetes Educator will offer targeted education on diabetes management and programs available to members	▪ Virtual supports to help manage member conditions, including telehealth kits (asthma, diabetes, BH) and remote patient monitoring ▪ Integrated CM program to monitor conditions, behaviors, risk factors, or unmet needs ▪ Provider website will include on-demand access to the latest evidence-based practices and clinical practice guidelines for chronic conditions like diabetes, asthma, and obesity
(e) Children in Foster Care	▪ Foster Care Specialists and Peer Support Specialists will educate providers on meeting needs for foster care members, including their SDOH needs ▪ MCH/EPSDT Coordinator and EPSDT Specialist will educate providers on conducting screenings and closing gaps	▪ Targeted training and incentives for Adverse Childhood Experiences (ACEs) screenings and referral to treatment ▪ Training on EBPs and support for providers becoming credentialed in emerging EBPs ▪ EPSDT and trauma toolkits ▪ Toolkits developed with Got Transition® (a federally funded national resource center on health care transition) through the National Alliance to Advance Adolescent Health that support a patient-centered approach to maximizing health outcomes including Supportive Decision Making, Transition Readiness Assessment, Questions to Ask Your Doctor, Changing Roles [of youth as they take more control of their health and health care], and Planning to Move from Pediatrics to Adult Care

Provider Education and Training Workplan

Healthy Blue maintains a provider education and workplan that outlines the content and timing of provider training offered through the Academy. This includes detail on our approach to provider education and training, including offered modalities (for example, virtual, on-

site), new provider orientation training, appropriate communication channels for different communications (for example, mail, Email, Fax Blast, Provider Website), provider resources available through our public provider portal.

We conduct provider orientation trainings at least monthly, including targeted BH training. We record all trainings and offer them on-demand. We also offer training tailored to the specific audience or need, including topics such as needs assessments, billing practices, and facilitating industry best practices. In addition, our Provider Experience team is available to deliver on-site training support upon provider request or should Healthy Blue identify a concern that requires one on one assistance. For example, a large OB-GYN provider had over $100,000 in outstanding claims. The provider reached out to Dr. Rhodes for assistance. The provider's Provider Experience Representative met with the providers onsite to help identify and resolve the issue. The Provider Experience Representative reviewed hundreds of claims and performed a root cause analysis which revealed that the clinic was not billing up to the allowable amounts and needed to make changes to their charge master. The clinic was then able to resubmit claims and receive timely resolution of the issue. The Provider Experience Representative also provided onsite education on claims submission and standard industry billing practices, thus preventing future issues.

Healthy Blue Care Delivery Transformation Consultants and our Quality Management team also collaborate with Provider Experience Representatives to offer regular and ad hoc education, training, and technical assistance to providers on such topics as quality measures and value-based purchasing programs.

In 2021, the Healthy Blue team conducted multiple training sessions, outreach activities, orientations, and visits with providers across the Healthy Blue provider network, including 307 provider visits across 48 counties, and provider training on gap closures, authorization, telehealth, and Healthy Blue supportive tools (for example, the Provider Portal). Our Provider Experience staff also hosted quarterly virtual and on-site Town Halls, which included Healthy Blue leadership and monthly meetings, and participated in numerous State association and conventions throughout the year, including the Rural Health Conference and Tribal Association Meetings. We also use specialized FQHC Provider Experience Representatives to outreach all FQHCs, key primary and specialty care providers.

Healthy Blue 2022 offerings, informed by provider demand and need, include telehealth, health equity, 2022 coding updates, Category II coding, and BH and SUD.

Healthy Blue Content Distribution

Healthy Blue sends a welcome letter when each provider joins the network which serves as the initial introduction to Healthy Blue. The welcome letter includes onboarding information and alerts providers to provider orientation requirements and schedules, as well as training and education resources available through our public website and secure Provider Portal, Availity. We send all new providers a New Provider Orientation packet, which includes information on Healthy Blue, Compliance, Quality Management, Partner Services, Provider Resources, and Joining our Network. This detailed packet includes hotlinks to our public website and secure Provider Portal. We also alert providers to training and educational resources through our Provider Experience Representatives, electronic and mailed flyers (as shown in Figure V.J.43-2) advertising events (such as Town Halls and educational seminars). For convenience, we have added QR codes to most alerts, which allows providers to use their smartphones to review and register for events.

Figure V.J.43-2. Healthy Blue Distributes Flyers to Educate.

Additionally, we also use the following channels to distribute content to providers:

- **Email.** Healthy Blue utilizes email to send some bulletins, policy change notifications, prior authorization update information, educational opportunities, and other communications.
- **Provider Newsletter.** Our monthly newsletter includes quick reference sections on topics providers care about the most, including claims filing, products and other benefits, administrative updates, new or revised procedures or guidelines, prescription information, and more.
- **Provider Bulletins.** Bulletins provide short, topical articles on new features, plan updates or policy changes.
- **Provider Experience Representatives.** This team alerts providers to trainings and other opportunities of interest to the provider.

We provide the following three samples of distributed content in our Attachment V.J.43-1:

- Provider Education and Training Materials Sample- Caring for Diverse Populations Toolkit
- Provider Education and Training Materials Sample- Healthy Blue New Provider Orientation
- Provider Education and Training Materials Sample- Provider Coding Education (CME/CEU) Registration Flyer

Approach to Assessing the Usefulness of Educational Sessions

We view provider training as a continuous, evolving process and a foundational element of our strategy to assure equitable, whole person care to members. Our approach to assessing the usefulness of our training and education program in grounded in continuous quality improvement cycle. Two-way communication between Healthy Blue and the provider network is of the utmost priority. We continually seek feedback from our providers through multiple avenues and incorporate feedback into our Provider Experience model. For example, we have been particularly responsive to provider needs throughout the public health emergency, transitioning face-to-face meetings to virtual and increasing our offering on the use of telehealth and Healthy Blue telehealth options.

We continually refine our approach to meet the needs of providers, and use insights gained from various forums, provider satisfaction surveys, provider experience FAQs and FAQs from Association meetings, Nebraska Medicaid provider forums; MLTC and other key stakeholder feedback; Provider Advisory Council feedback; and through analysis of trends identified through our Quality Management processes and understanding of emerging trends in the Medicaid population. We also use attendance figures and provider feedback gleaned during a post training survey. The survey solicits provider feedback on the courses effectiveness in achieving its learning objectives; the usefulness of the knowledge, skills, and information gathered during the training to the provider's practice of medicine, and the sufficiency of the training materials and assistance provided by Healthy Blue during the course. We incorporate provider feedback via post-training survey data to develop and refine our training materials and will communicate information back to providers through multiple channels, (for example, in person, virtual, or digital).

In addition, our Provider Experience team meets on a regular basis with our Chief Operating Officer to make sure they are proactively identifying and addressing any claim submission trends identified and provide necessary ad hoc training or process update communication to providers. Our Provider Claims Educator will be a primary contributor to the development and administration of the monthly claims training offered to Providers. We discuss claims trends weekly at Provider Experience team meetings.

> *Our representative with Healthy Blue [HB] is always a great help. She is prompt on answering emails and is very consistent with monthly meetings with our coding staff to answer all questions and concerns. She takes the initiative to send HB updates and information from their website that pertains to issues we have discussed with her. HB's regular Town Hall meetings have been a great source of information as well.*
>
> *The Healthy Blue staff en masse is accomplished and helpful. When we reach out to HB we are given the help needed or directed to the appropriate contact. This has saved us much wasted telephone time which is invaluable for a busy practice such as ours. Claims are handled with efficiency and accuracy.*
>
> *In addition, Dr. Robert Rhodes has been a valuable asset to Healthy Blue as an involved and easily accessible leader. When we experienced problems at the beginning of our relationship, Dr. Rhodes personally came to our clinic. He listened to our concerns and ensured that they were dealt with and resolved to our mutual satisfaction.*
>
> **Todd A. Pankratz, MD**
>
> NE_HH22_ToddPankrats_TST_02

Due to growing interest in education on telehealth, our Provider Experience team now includes a *Telehealth Program Manager*, who will collaborate with Providers to assure that they have the information and resources needed to successfully implement or expand telehealth services in their practices, including assistance with technical and billing issues. Healthy Blue's Care Delivery Transformation (CDT) Consultants provide consultations with our PCPs who participatein our VBP programs to provide enhanced education on how to improve quality outcomes and close gaps in care for children and members with chronic conditions. This includes EPSDT, lead screening, asthma, prenatal care, dental care, behavioral health care, emergency department reduction, and how to refer members to case management. We will be adding two more resources to this team in 2022.

No. 44

Our Approach to Provider Communication

Provider Promise

Healthy Blue developed our provider communication approach around the principles embodied in our Provider Promise, to simplify health care so providers can focus on the health of our members. We do this by using our communication approach to engage, incent, and empower our providers to support transformation across the system of care. We have established policies and procedures (P&Ps) to guide our approach, building on our Nebraska experience as well as best practices gleaned from our affiliates operating in 25 other Medicaid markets. Our P&Ps assure we meet or exceed regulatory compliance considerations, such as HIPAA, and we design them to simplify program and service navigation to give our providers easy access to the information they need to better serve our Nebraska members.

Our approach relies on proactively engaging and supporting our providers with a variety of communication tools that are easy to access and use. In keeping with our promise of administration simplification, we tailor our communications to the provider's preference — in-person, telephonic, e-mail or web-based. We also take time to listen to providers' needs and make sure we offer providers the right level of support and engagement without creating additional administrative burden.

We offer an array of communication methods and tools to support our approach and execute on our Provider Promise to meet our providers where they are and deliver a seamless experience, such as:

- New Provider Orientation and continuing provider education and training
- In-person and virtual provider visits from assigned Provider Experience Representatives
- Provider Advisory Committee (PAC) which gives providers a forum to voice concerns and make recommendations
- Continual provider association engagement
- Our provider website and secure provider portal, including a provider chat function
- Provider newsletters and the provider handbook, available on the provider website
- Provider bulletins, faxes, and email messages that proactively update providers programs and operational changes
- Webinars, workshops, and forums, including annual and quarterly agency training events
- Immediate telephonic response through our Provider Services Helpline

We Collaborate with Providers to Improve Administrative Efficiencies

Healthy Blue continually looks for opportunities to alleviate administrative burden and inefficiencies. Our provider communications strategy is grounded in a continuous quality improvement (CQI) cycle. Two-way communication between Healthy Blue and the provider network is of the utmost priority, and we continually seek feedback from our providers through multiple avenues and routinely incorporate feedback. We continually refine our approach to meet the needs of providers identified through various forums, such as direct input from our network providers, including insights gleaned from our annual Provider Satisfaction Survey program; provider experience FAQs and FAQs from association meetings; committees and provider forums; feedback received from key stakeholders; and through analysis of trends identified through our QM processes. Our administrative monitoring processes include:

- **Under and Over-Utilization.** We monitor gaps in care and utilization reports to identify trends across the membership that may be indicative of a need for changes to our outreach and engagement strategies, including provider communications.
- **Call Center Data.** We capture the types of calls we receive from providers, including calls that reflect confusion about our processes or requirements. By analyzing these call reasons, we can trend opportunities to improve our messaging. We also assess provider complaints and grievances to gain direct input on improvement opportunities. We report these data through committees with recommendations for revisions when opportunities arise.
- **Access and Availability Audits.** We monitor trends from our Access and Availability audits that may be indicative of a specific provider type requiring education on appointment wait time and after-hours requirements.
- **Ad-hoc Provider Surveys.** A recent addition to our provider feedback collection methods, providers can complete our ad-hoc provider surveys anytime through our provider website and through a link in our staff's email signature lines. The survey allows us to understand provider experiences and identify areas of deficiency in real-time and in between administering our yearly surveys.
- **Provider Listening Sessions.** As a part of our strategy, we will hold listening sessions with providers and provider associations to understand issues, including local access challenges and nuances within the state. We have conducted these sessions both in-person and virtually to assure greatest access and safety during the pandemic.

In response to provider feedback and results from the monitoring strategies listed above, we have implemented new technological tools to improve the provider experience. Our multi-payer secure provider web portal, ***Availity***, gives providers a single point of access to tools that simplify their work. Providers can use the portal to check eligibility, request prior authorizations, manage member care, and submit claims. Providers can also use the portal to access information about programs, link to trainings, and submit inquiries to our team of experts with instant response capability. [redacted]

We Engage Providers on Clinical Policies and Operational Issues

Healthy Blue has employed numerous methods to engage our provider community and get feedback to help us improve clinical policies and operational issues. Our skilled Provider Experience (PE) team, QM team and Provider Claims Educator all collaborate to implement these strategies and assure that we support our provider network and address issues that impede their ability to deliver the best possible care.

- **Provider Advisory Committee (PAC).** Our committee holds collaborative meetings with provider groups, in addition to joint statewide provider workshops. Our PAC meetings offer providers a venue to issue feedback on all aspects of our operations, including processes, policies and procedures, and provider services including but not limited to prior authorization and claims. The PAC is comprised of Nebraska providers representing multiple provider types, including both physical health and BH and that represent organizations such as FQHCs, clinics and hospitals, and physical therapy and occupational therapy providers.

- **Example Highlight***:* During a recent PAC meeting providers expressed concern they were not receiving a tracking number when they submitted a request to the provider data mailbox. Our investigation revealed some groups use a "do not reply" email. As a result, automated emails with the tracking number did not make it back to the provider group. Our PE team worked with those groups to educate them on the process and resolve their issues.

- **Provider Townhall meetings.** Townhall meetings occur quarterly and give providers an opportunity to learn about topics such as authorization, credentialing, claims issues such as claims dispute process and overpayment recovery and refunds, appointment availability requirements, and tools and resources available to providers. Our townhall meetings also include an open forum question and answer session to address provider questions in real-time. The quarterly townhall meetings routinely draw more than 75 providers of all variety of specialty both in physical and behavioral health.
- **Provider Surveys.** We conduct annual surveys to question providers understanding and gain critical feedback directly from providers on how we can improve. We solicit direct provider feedback on the effectiveness of our communication tools, including our provider handbook, remittance advice, care coordination between physical health and BH, training modules and more. We conduct additional surveys with our providers on CM, UM, and Disease Management programs. These separate surveys for each program give us critical input on how the programs are helping our members and how we can improve them to drive better health outcomes. We also gain critical insights on methods to improve provider collaboration.
- **Provider Complaints.** We process and respond within required timeframes to all provider complaints and log them in our system for tracking and trending purposes. We assign issue codes to the complaints so we can identify trends and work to resolve them as we identify them. We use this information to find areas we can improve, including working with internal partners to resolve technical and system issues, or identify instances where additional education could prevent provider frustration in the future.

> *Since 2021 we have come to value and appreciate our relationship with Healthy Blue with a renewed spirit and a renewed sense of optimism. They have shown that they care about the health and well-being of Nebraska Medicaid members, and they have shown us that they also value their relationships with providers. As providers, feeling valued and respected has created a culture and climate of collaboration instead of an adversarial relationship that often lingered before. Through this, the focus has shifted…to what it should be…on the patients we serve and providing medically necessary care for Nebraska Medicaid members.*
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> **Jared Ray**
> Director of Operations at Pine Lake Behavioral Health & Medical
> NE_HH22_JaredRay_TST_01

Our Provider Advisory Committee (PAC)

We take our PAC's feedback seriously and use insights to enhance our programs to make them most meaningful for providers. Our Provider Network Liaison will work with our PAC members to make certain that meeting agendas include topics of their interest and priority. The Provider Network Liaison will develop and maintain positive relationships with our provider community through visits, communicating administrative and programmatic changes, and facilitating education. Our Provider Network Liaison will provide expertise on the complex concerns and issues that affect provider satisfaction and will work with the PAC to address provider concerns and develop provider training.

We Collaborate with Providers to Identify and Implement Changes

Our PE and QM teams use the results from our provider feedback data sources to evaluate and intervene with providers to improve their performance and identify trends that indicate a need for revisions to our provider communication strategy. We evaluate trends through our Service Quality Committee (SQC) and Quality Management Committee (QMC) and begin with a root cause analysis to determine the full array of factors contributing to performance that does not meet identified targets. This analysis drives development of our annual quality workplan and solidifies our interventions and provider communication strategies and tools that the PE team use. A few examples of our enhancements initiated because of this review process are:

- **Streamlined Communications.** We received feedback from our providers that they were receiving too many lengthy communications from each of the health plans. To streamline communications, we created and distributed our monthly provider newsletter which is a more condensed snapshot of the most relevant provider information.
- **Quick Responses.** Our providers told us that they wanted a faster way to get responses from us for questions related to claims and prior authorization requests. ***As a result, we added the provider chat functionality to our secure portal through Availity so providers can get immediate answers to these types of questions***.
- **BH-Focused Education.** While conducting provider orientations, we learned that BH providers would benefit from an orientation tailored to their specific needs. In addition to creating a specific BH Provider Orientation, Healthy Blue will designate a BH Integration Practice Consultant who conducts training and support. Our BH Medical Director, BH Director, and BH Case Managers will support this individual to provide continued ongoing provider education on BH appointment requirements.
- **Trauma-Informed Training**. In alignment with DHHS's Oversight Committee's goal of providing quality trauma focused care to youth, we sponsored a three-day nationally certified training on Trauma-Focused Cognitive Behavioral Treatment. In addition to the training session, attendees received 12 consultation sessions with the trainer as they worked their client cases. Fourteen therapists completed the training, representing the cities of Sydney, Ogallala, Kearney, Grand Island, Norfolk, Omaha, and Lincoln. Due to the positive feedback from attendees, we will offer the training again in 2022.

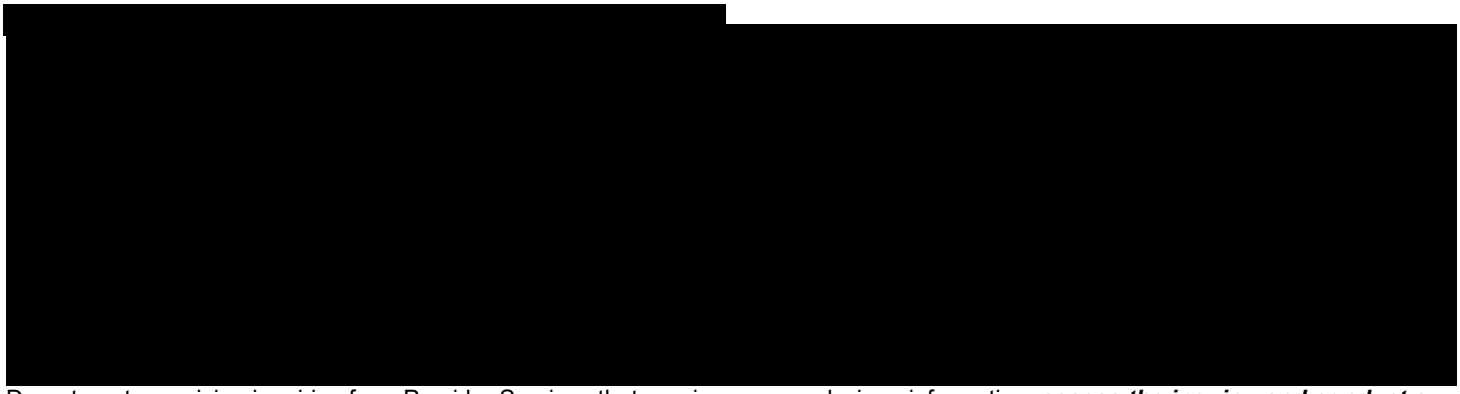
No. 45

Approach to Handling Provider Complaints

Healthy Blue resolves provider complaints in a timely and accurate manner, which minimizes escalation to MLTC. We use a no-wrong-door approach to capture, monitor, and track provider concerns. This approach allows us to take systematic action as necessary to resolve issues. Our goal is to address all provider complaints using the feedback we receive to improve the overall Nebraska provider experience.

Interacting, Corresponding, and Timeframes for Acknowledging and Resolving Inquiries and Grievances

Our toll-free Provider Services line responds to provider questions, comments, inquiries, and complaints. Provider Services employees immediately acknowledge provider calls and attempt to provide ***first call resolution*** using all available tools and resources. If we are unable to resolve the concern during the call due to the need to engage another department for review or other action, the details of the provider complaint are documented in our customer service integrated desktop application and routed to the appropriate department for resolution. The inquiring provider is informed verbally, during the call, of the expected timeframe for resolution, not to exceed 30 business days for a standard complaint and three business days for an expedited complaint (this includes referrals from MLTC). In addition to our Provider Services line, providers can also share questions, comments, inquiries, or complaints in writing (including our provider portal), or in person. The process for in person and in writing submissions is the same since the information received is documented in our customer service integrated desktop application and routed to the appropriate department unless the inquiry can be resolved with a simple response to the provider. The timeline for provider complaint highlighted in Figure V.J.45-1.



Departments receiving inquiries from Provider Services that require more analysis or information, ***assess the inquiry, and conduct a thorough review by following-up with the provider within three business days of receipt of a standard complaint or one business day if it is an expedited complaint***. The departments, including Provider Relations, maintain operating standards that include generating provider complaint reports on a routine basis and processes to assure resolution of logged Provider Service issues within 30 business days or within three business days for an expedited complaint. All routed items are worked by the assigned employee who documents provider interactions and follows up in a clear, concise, and professional manner. Once the inquiry is resolved with the provider, the assigned employee closes the item assuring resolution is within 30 business days or within three business days it is an expedited complaint. Additionally, we run monthly reports and perform oversight to confirm compliance with the 30- and three-day resolution timeframes. We review the results, and request corrective action plans to resolve non-compliant items when necessary.

All Provider Services employees can open, view, and resolve Customer Service Logs to assist providers with their open questions. Reporting is also available from all systems in which Customer Service Logs are created, and our call center system tracks provider call management metrics. We measure and monitor the accuracy of responses provided by our Provider Services employees, and we report this monthly to MLTC. We take corrective action as necessary to assure the accuracy of responses by our employees.

For after normal business hours, our Provider Services line includes recorded information regarding normal business hours, and 24/7 self-service eligibility check, precertification lookup tool, prior authorization status check, and claims status check through our IVR system. All of these things can also be done 24/7 through our provider portal. No verification is ever required before providing ED services and care, and we have a separate line dedicated to pharmacy and prescription issues, including member copayments, if applicable.

Provider Claims Payment Disputes. We encourage providers to submit a claim reconsideration for any claim they believe was processed incorrectly. Our approach to claims payment disputes includes a simplified process for providers to submit complaints related to authorization or denial of service, payment, or non-payment of claims, and timeliness of reimbursement. Upon receipt of a provider claims payment dispute, a Provider Payment Reconsideration Analyst investigates the dispute, using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's and MTLC's written policies and procedures.

We review all claims payment disputes to identify the root cause and address the matter whether it is an isolated provider concern or a trending issue. Our COO and Medicaid Claims Dispute team oversees our Provider Dispute Plan and is accountable for making sure we meet all Contract standards. Our Grievance System Manager, Claims Administrator, and Provider Claims Educator are supported by our trained and experienced Provider Experience Representatives, Claims Analysts, and clinical experts (for example, MDs) who work together quickly and efficiently to resolve provider disputes.

If we identify a system error that affects provider claims payment, we immediately implement a system update to correct the error while concurrently running an analysis to identify all impacted claims. Once this analysis is complete, we immediately develop and implement corrective action to reconcile the claims of impacted providers. Running in parallel to the root cause analytics, our Provider Experience team is provided with a comprehensive overview of the issue so they can outreach to impacted providers and inform them of our plan of action. We make every effort to minimize the impact to provider's administrative responsibilities and have a process in place to

proactively perform claim adjustments without the provider having to refile claims. We target a 30-day completion time for all claim adjustment projects.

Providers may also appeal the decision on their dispute if they are unsatisfied with the outcome. The appeal must be submitting in writing (by mail or through our provider portal) within 30 calendar days from the date on the reconsideration determination letter. As with disputes, we log every appeal in a central location. A complete description of our Provider Dispute policies and procedures is available in our Provider Handbook and we share reminders on the Dispute process in our quarterly provider townhalls and monthly Provider Newsletter.

Tracking Provider Complaints and Using Information to Improve Provider Services

We systematically monitor and track every contact point where we receive provider complaints. Our provider complaint system tracks the receipt and resolution of provider complaints from in-network and out-of-network providers. Compass identifies and tracks provider complaints received by telephone, in writing (including our provider portal), or in person. As part of our provider complaint system, we have a specific Provider Services team for providers to contact via telephone, chat, email, mail, and in person, to ask questions, file a provider complaint, and resolve problems. Our Provider Services team receives and processes provider complaints. This team thoroughly investigates each provider complaint using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying MLTC and our written policies and procedures. We also assure that our executives with the authority to require corrective action are involved in the provider complaint escalation process. The names, telephone numbers, and email addresses of these individuals will be provided to MLTC within 15 calendar days of contract signing, and within two business days of any changes.

Provider Complaint System Policies and Procedures. We have written policies and procedures that describe our provider complaint system, and we will submit them to MLTC for review and approval at least 60 calendar days before the Contract Start Date. Our policies and procedures, include:

- Description of the filing process and the resolution timeframes
- 30 calendar days for providers to file a written complaint
- Description of how providers may file a complaint with us for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function
- Description of how our provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf
- Process for providers to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues
- Process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation
- Description of the methods we use to assure our executive staff with authority to require corrective action are involved in the complaint process, as necessary
- Process for giving providers (or their representatives) the opportunity to present their cases in person
- Identification of specific individuals who have authority to administer the provider complaint process
- Description of our system, Compass, that captures, tracks, and reports the status and resolution of all provider complaints (whether received by telephone, in person, or in writing), including all associated documentation

We distribute our policies and procedures to in-network providers and subcontractors at the time of contracting and to out-of-network providers with remittance advices. We also include a description of our provider complaint system in our provider handbook and on our provider website with specific instructions on how to contact our provider services staff and contact information for our team that receives and processes provider complaints.

Improving Provider Services with Provider Complaint Information. Our Provider Experience team continuously mines data and monitors for trends and commonalities so we can quickly identify issues and implement solutions to address the trends. We use these reports to spot trends and patterns that could indicate something is potentially wrong with our claims system, provider reimbursement, or other policies and procedures. The information we receive from provider complaints helps identify opportunities for increased provider communication and engagement. We take provider complaints seriously to make sure they do not involve systematic errors that could lead to larger scale payment issues, network disruption, or unnecessary administrative burden for our providers or MLTC. Additionally, our Quality Assessment and Performance Improvement (QAPI) Committee and Provider Advisory Committee track provider complaints. For provider complaints, we track a variety of key factors, including:

- Total authorization volume dashboard – by month, product, inpatient and outpatient, bed type, diagnosis-related group, procedure code, length of stay
- Authorizations approved or denied and percentages
- Administrative denials and percentages
- Medical Director review volume, denial rates, peer to peer discussions, and appeals

If we identify a pattern or trend across multiple providers that may indicate the presence of a systemic issue, our local Nebraska Operations team works to identify the reason for the increase in provider complaints. We use root cause analysis techniques to get to the source of the concern quickly, and we use several tools and reports to detect system issues or errors. Some examples of affiliate enhancements resulting from identifying system issues, include:

- Implementation of our ***Provider Collaborative Resolution Model***, which partners members of our Operational Excellence team with our Provider Experience team to conduct on-site provider visits to address outstanding provider questions and concerns around claims issues
- Integration of our ***Provider Reconciliation Scorecard*** to support the resolution model to provide collaborative feedback quickly and consistently to providers when claims issues arise
- ***Optimization of our encounter data submissions*** including performance improvement to 99.8% Accuracy of monthly claims submissions

Specific Nebraska examples of listening to provider concerns and improving our service to providers, include:

- During a MLTC listening session when providers expressed concerns, our Provider Experience team emailed or called each provider within 24 business hours of the session. We documented the outreach provided senior leadership with updates until all

parties were satisfied with the outcomes. One provider expressed concerns over a large volume of unpaid claims since the transition from WellCare to Healthy Blue. Our Provider Experience team emailed both the office manager and the COO regarding the concerns. Contact was made via email on three consecutive days and on the third day a phone call was place to the COO at which time a virtual meeting was scheduled for the following week. During the meeting Provider Experience was able to obtain the necessary information from the provider to assist in resolving the claims with WellCare. The provider expressed gratitude and appreciation for our prompt outreach after the listening session, and our Provider Experience team continues to meet with this provider on a routine basis to help cultivate the relationship.

- The president elect of the Psychological Association of Nebraska voiced concerns on behalf of the association, including authorization requirements being unclear, administrative burden to practitioners to obtain authorizations, and the peer-to-peer reviews. During a listening session, our Manager of Provider Experience emailed the president elect and offered to schedule a time to visit one-on-one regarding the concerns. A virtual meeting was scheduled for two days later, and the president elect stated that the authorization process impedes the work of practitioners because the amount of documentation required and unsure of expectations, as well as the length of time for testing. Following the virtual meeting our Provider Experience team worked with internal departments and arranged a training for the psychological association. Additionally, one of the psychologists at our parent company reached out to the president elect and provided additional clinical insight.

Influencing the Activities of Our Provider Services Representatives with Internal Reporting

We continually analyze data and information to identify opportunities for improvement. We categorize each complaint in a database to identify specific trending and improvement opportunities. We use a Tableau Dashboard (a visual analytics platform) with data organized multiple ways to allow our teams to identify trends and engage targeted deep dives on emerging issues by provider, claim action code, or other criteria. As trends or outliers emerge, we conduct a root cause analysis and promptly engage the appropriate stakeholders to resolve them. If we receive a high volume of a particular type of complaint related to claims payment, we examine our internal systems to remove any barriers to efficient payment or re-educate providers on what is required for the claim to process. We produce and use routine and special management reports to identify potential areas for service or quality improvement. The data tracking system allows for reporting by region, provider type, complaint type, and the number of items per 1,000 members.

Our Provider Disputes leadership team meets monthly to review internal reports and current trends in provider dispute data, identify emerging issues based on the data, and determine opportunities to influence the activities of our Provider Services representatives to address issues before they evolve into a dispute. Our Operations Experts review internal reports daily to confirm timely assignment and completion of disputes. Our Provider Disputes team hosts a monthly meeting with key stakeholders in the provider dispute process to discuss additional opportunities for improvement. The goal of these meetings is to collaborate with our Provider Experience and Operations team to review the dispute activity over the prior month and conduct a deeper analysis on items identified to develop a plan of action. We also review trends and feedback from providers to reduce their administrative burden. If disputes related to burdensome prior authorization requirements are received, we review the denial rate for the services(s) to determine if providers are managing medically necessity appropriately. Based on our findings, we will consider removing specific codes from our prior authorization list when appropriate to minimize burden on providers.

Additionally, our Provider Experience team also leverages internal reporting, including network provider report, PCP panel reports for providers, provider claim summaries, and claims rejections, to educate and help illustrate trends for providers. For example, the Provider Experience team uses the network provider report to assist providers in confirming the appropriate providers are associated with their Tax ID to prevent issues with claims payment. This process also helps illustrate the importance of completing the credentialing and rostering of their providers.

No. 46

Commitment to Supporting Provider Use of Electronic Health Records

Healthy Blue believes health information exchange (HIE) throughout the health care ecosystem is critical to enhancing the ability to provide holistic and patient-centered care to all Nebraskans and to support higher quality care and better outcomes. By sharing vital information, we can improve member outcomes, simplify workflows, and reduce provider administrative burden. We understand that the adoption and use of electronic health records (EHRs) is critical to delivering safe, appropriate, and efficient care as well as a prerequisite to enabling HIE among stakeholders collaborating in the provision of care to Healthy Blue's members. We are committed to working with MLTC and Nebraska providers to implement all solutions that support the effective exchange of data exchange with MLTC and other stakeholders. We will provide MLTC with any reports requested.

[redacted]

No. 47

Engagement and Education of PCPs Regarding Their Role in the Provision of Behavioral Health Services and the Coordination of Co-existing Conditions

Healthy Blue is committed to implementing innovative, integrated solutions that address whole-person needs. As a current MCO serving Nebraska members, we continue to coordinate the full range of behavioral health (BH) services, integrated with physical health (PH) services, to address member health care, social determinants of health (SDOH) as well as other needs, and we do this in collaboration with our PH and BH providers. We apply whole-person, evidence-based, collaborative, and community-focused principles to support members. Our focus is on assuring members receive the right care, in the right place, at the right time. We are supported by our parent organization, which has more than 26 years of experience supporting BH services across 26 affiliates. This includes a NCQA Managed BH Organization (MBHO) accreditation in 2018, which reflects our organization's commitment to following evidence-based practices for providing high-quality care, access, member protections, and integration of BH and PH at the health plan and practice levels. In addition to our core metrics and programs, we have been working together with our parent organization to build a sustainable population health management model that addresses member needs across the continuum and deploys targeted resources effectively to achieve positive health outcomes, appropriate utilization, member satisfaction, and program savings. As part of bridging BH and PH services integration in primary care settings, we also reimburse CMS CPT® codes for Collaborative Care.

Advancing BH Integration

Healthy Blue partnered with the Behavioral Health Education Center of Nebraska to co-sponsor two conferences demonstrating and promoting the Collaborative Care model of BH integration.

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Engaging and Educating PCPs Through On-site Visits

Our approach to engaging PCPs leverages our provider experience model. Provider Experience team members support all providers, including BH providers, throughout our network. This team works alongside the BH Clinical Director and Behavioral Health Manager for BH to identify and provide ongoing education and training to the BH network and PCPs, PCMHs, Federally Qualified Health Centers (FQHCs), tribal providers and other providers who treat members with co-existing conditions. Our BH Clinical team has made it a priority to visit Nebraska providers in person. During these visits to providers, we discuss their scope of services and their experiences with Healthy Blue. At this time, we have visited all six BH Regional Health Authority offices in person to hear about their programing and share details about our programing.

We focus on engaging and educating PCPs about their role in the provision of BH services by completing on-site provider visits with our integrated clinical team, which includes members with expertise in BH and PH treatment. Our integrated clinical team completes on-site visits throughout Nebraska, including rural settings, offering ***monthly webinars and EPSDT-focused discussions and education during on-site visits***. We assist PCPs with notifying and informing members about the EPSDT periodicity schedule. Our provider portal and provider handbook also include EPSDT trainings and educational materials.

Our integrated clinical team visits providers ranging from PCPs to hospitals, and focuses on discussing scope of services, obtaining authorizations, discharge planning, clinical information, and experiences with Healthy Blue. For PCPs enrolled in our value-based purchasing (VBP) programs, our Care Delivery Transformation (CDT) Consultants conduct an initial orientation with new pediatric providers and update them on ongoing performance areas, including EPSDT; Screening, Brief Intervention, and Referral to Treatment (SBIRT); and other possible BH screenings completed by PCPs. Our CDT Consultants send gap-in-care reports to providers engaged in our VBP programs to identify which members on their panel are coming due or are overdue for EPSDT wellness or prevention visits.

Educating and Engaging PCPs Through Comprehensive Training and Support

Beginning this year, we started offering ***Matrix Model Training*** through our online ***Medicaid Training Academy***. This two-day training is initially available for select providers with integrated capabilities and multiple specialty types, particularly PCP and BH providers who participate in VBP programs. The Matrix Model of Intensive Outpatient Treatment (IOP) is an evidence-based treatment for members with methamphetamine, alcohol, or other substance use disorder (SUD). Programs that have implemented this model report significant improvement in treatment outcomes. We also support and coordinate with community agencies offering these services, such as Heartland Family Service. Additional Nebraska training and committees we participate in include:

- DHHS Health Oversight Committee (trauma risk assessment group)
- DHHS Family Centered Services work group
- DHHS CARA work group
- Division of Behavioral Health (DBH) IOP Matrix
- DBH assertive community treatment/alternative community treatment team training

We educate and encourage PCPs to use BH services. [redacted] This training discusses the delivery of BH care in primary care settings, with a focus on evidence guiding practical skills needed to function as a primary care consulting psychiatrist. Topics included supporting accountable care, leadership essentials for psychiatrists, payment, and an introduction to implementation strategies for PCPs. To further promote comprehensive coordination of care, we will also help providers attain PCMH recognition through assistance from our PCMH Transformation Consultants, BH Integration Consultants, and Transformation incentive payments.

We provide education on clinical information necessary to obtain authorizations and treatment and discharge planning. We have created and distributed a guide for understanding medical necessity and the prior authorization process for Healthy Blue providers. This guide outlines psychological testing criteria, neuropsychological testing criteria, common reasons for denial of testing, and how to

handle denial. We also distribute a bulletin for frequently asked questions and answers. Educating providers on testing criteria means providers are more aware of process, less likely to have a service denied, and better equipped to focus on member care.

Engaging and Educating Providers Incentives and VBP Programs

We will offer incentive payments to providers for incorporating evidence-based practice (EBP) interventions into the delivery of BH services to our members. Providers will receive this enhanced reimbursement by including an appropriate EBP tracking code along with a relevant CPT®/HCPCS code in their claim submissions. Examples of eligible EBP combinations may include the incorporation of parent-child interaction therapy or trauma-focused cognitive behavioral therapy into psychotherapy sessions. Prior to program implementation, we will provide education to providers on the appropriate billing and credentials that will be required to receive this enhanced reimbursement.

We will also implement new VBP programs for our Heritage Health providers to achieve improved member health outcomes, decrease health care costs, improve care, and promote PH and BH collaboration. [redacted]

During year one of the contract, we will engage all PCPs and PCMHs in VBP programs that reward specified improvements in child and adolescent screenings and immunizations, and for detecting and addressing early childhood trauma and BH needs. Our CDT Consultants will guide providers through VBP programs, including provider-specific reporting and outcomes. We will propose the inclusion of specific preventive care screenings and immunization measures in the statewide VBP program for implementation across community-based organizations.

Coordination of Co-existing Conditions

In line with the State's Health Improvement Plan priority of PH and BH integration, increased depression screening and suicide prevention, we are working with PH providers to incorporate a whole-person approach to care. PCPs, PCMHs, and OB-GYNs are often the first provider members with a BH, or SUD issue see for care. It is critical that these providers have screening tools they need to recognize signs and symptoms of a co-existing BH condition. We offer training, tools, and financial incentives to assist and reward PH providers for properly identifying members with BH and SUD needs, as well as connecting members to appropriate services and supports. We provide training and tools that support evidence-based practices that identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and narcotics. We supplement the PH providers' ability to conduct screenings by offering telehealth providers who can offer the screening service on their behalf. This screening can be conducted remotely while members wait for care in the PCP, PCMH or OB-GYN office. [redacted]

Assisting PCPs to Help Bridge the Rural Health Care Gap

Almost 20% of our members live in counties that have been classified as rural, and nearly 3% live in frontier counties. While access to PCPs in these counties consistently meets the standard, access to BH or SUD services can be challenging. [redacted]

Telehealth. We are leveraging telehealth to substantially reduce barriers to care by connecting members with their PCPs, specialists, and other providers more readily. The COVID-19 pandemic created an urgent need for telehealth, and 80% of our telehealth claims during the pandemic were BH-related. In 2021, 2,231 of our members living in Nebraska's rural and frontier counties used telehealth for BH services. We are assisting existing PCPs to expand their practice scope to integrate virtual services into their practice. We are also collaborating with the Rural Health Association to optimize telehealth to address workforce shortages.

[redacted]

Project ECHO. We are using Project ECHO to help with the collaboration of PH and BH services through telehealth and deliver provider education and care coordination that supports providers using evidence-based guidelines and tools to identify and treat opioid use disorder. We are collaborating with the University of Nebraska Medical Center to bring support to rural family medicine providers.

No. 48

Assuring Provider Satisfaction

Healthy Blue makes a promise to our providers: to deliver a best-in-class experience, simplify administrative processes, offer accountable reimbursement, and support them so they can focus on what matters most — the health of our members. Upon joining our network, every provider is assigned to a dedicated Provider Experience (PE) Representative who will reach out to the provider to establish an initial meeting, welcome them into the network, provide orientation based on the provider's preference, and work with them to establish ongoing regular interactions. In addition to providing initial and ongoing training, these PE Representatives will conduct on-site visits for high-volume specialists (for example, OB-GYNs) at least once per quarter to provide support and continuing education for providers and their office staff. The PE team will also offer hands-on, personalized support between those quarterly on-site visits, as needed, through phone, email, web portal, and additional on-site meetings as requested. We also know that providing timely, accurate claims payment and processes that reduce administrative burden increases the likelihood that providers will remain in our network and actively serve members. Our Provider Collaborative Resolution Model will partner members of our newly formed Operational Excellence Committee with the PE team to conduct on-site visits to address outstanding provider questions and/or concerns around claims issues. The Operational Excellence Committee is responsible for governance and oversight across multiple departments supporting Healthy Blue and includes representation from claims, quality, network compliance, provider data management, grievance and appeals, subcontractor oversight, encounters, and data capture and delivery. The committee's mission is to provide Healthy Blue leadership insight into and active involvement in all aspects of operations, including key performance indicators, remediation of risks, issues and challenges meeting operational performance metrics, and contractual requirements. ***Across our parent company and its affiliates, our collaborative relationships have resulted in less than 1% provider turnover and high satisfaction ratings. Less than 1% of our Nebraska Medicaid providers voluntarily terminate from our network.***

Provider Promise

[redacted]

n addition to the representatives available through our PE team, Healthy Blue's ***Provider Claims Educator*** identifies trends and guides the development and implementation of strategies to improve provider satisfaction. Those strategies include developing trainings based on the trends identified, such as common billing errors or new billing updates from the state around encounters or modifiers. These focused trainings lead to less claims denials, thus improving provider satisfaction. Our Provider Claims Educator, Theresa Ellis, has approximately 20 years of claims experience including coding, billing, EDI, and claims submission. She is not only well versed in the claims submission process but has extensive experience working in provider relations. Healthy Blue's ***Senior Network Manager*** works with medical, facility, BH, and ancillary providers to address access challenges in Nebraska's many rural counties and assure we are meeting the needs of our members and addressing concerns raised by the MLTC, and our members.

We leverage our relationships and deep understanding of Nebraska's Medicaid provider community to inform our retention strategy. ***As a result, less than 1% of providers voluntarily terminate from our network.*** Our successful provider retention strategy includes:

- Our local PE team serves communities across the state, engaging providers in person and virtually to build relationships. ***Since 2021, this team conducted more than 600 virtual visits.***
- Customized value-based purchasing (VBP) programs that offer financial rewards for high-quality, cost-effective care, and the right level of personal support with CDT Consultants to help providers achieve success in these programs.
- On-demand technical assistance to help providers succeed, such as proactively contacting providers if we identify possible submission errors through ongoing claims review.
- Practices to simplify and minimize administrative burden, including online claims, prior authorization submission, and advanced technology for provider demographic updates. New system features strengthen our ability to match submitted claims for more accurate pricing and processing.
- Tools and resources to expand practice scope, including training and comprehensive telehealth programs.
- Practice integration solutions to increase bidirectional data exchange.

Assessing Provider Satisfaction

Improving ***provider satisfaction*** is core to everything we do and is ***how we measure success***. Since launching the PE model in March 2021, ***we have brought intense focus to service***. Understanding how we are performing with respect to administrative areas is important because the more we simplify provider interaction with our health plan, the more time providers have to care for our members. We value the role that providers play in the lives of our members and are committed to collaborating to create solutions to improve access, coordinate services across the delivery system, and improve quality outcomes for members. Understanding that satisfaction is key to our partnership with providers, our Provider Advisory Committee (PAC) will collaborate to employ several methods to gauge provider satisfaction with the services and support that we provide. We obtain regular provider feedback through PAC, peer-to-peer discussions between providers and our Medical Directors, and annually through our provider satisfaction surveys. We will leverage the input we receive — whether through surveys, feedback, or data analysis to enhance or improve existing processes, training, and engagement activities. We obtain provider feedback to help improve our utilization management (UM) processes and identify requirements that are burdensome or unnecessary.

Annual Provider Satisfaction Surveys

In accordance with SOW V.M.14, we will conduct an annual Provider Satisfaction Survey and will submit a report to MLTC within 45 days of the end of each calendar year outlining how the results will inform our quality improvement work plan. Developed in collaboration with MLTC and the other Heritage Health MCOs, the survey of medical and BH providers will gauge satisfaction on topics including provider credentialing, service authorization, MCO staff courtesy, network management, appeals, claims reimbursement, provider communication, and UM processes. The Provider Satisfaction Survey, which incorporates the Behavioral Health Provider Satisfaction Survey, is distributed by our Medicaid Network Program Services Team. The PE team receives the results and the results from the survey will be reported out through the Quality Assessment Performance Improvement Committee (QAPIC), which will track and trend data and identify areas of opportunity and solution development. We continue to analyze the results and plan to conduct future surveys, and we will continue to leverage this input to inform our strategies and build collaborative relationships with providers. For example, a member of the PE team reaches out to the 26% of survey respondents, each individual provider, that did not respond in the survey as "satisfied" or "very satisfied." This direct and personalized outreach helps us identify what our providers want and how best to support them. Our provider-centric approach focuses on how we can improve the provider's experience. The PE team member works with the provider and provided education when needed, with the intent to evolve the relationship from payor/payee to partners.

Healthy Blue will also work in conjunction with MLTC and other MCOs to develop an annual provider survey tailored to dental providers to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims, processing, claims reimbursement, and UM processes. The Dental Provider Satisfaction Survey will be administered by our dental partner, Liberty Dental Plan.

Provider Training

Healthy Blue provider trainings and workshops will be conducted by our PE team. We understand the importance of educating and training our network providers and will develop programs in compliance with the SOW. We will leverage experience and best practices in our affiliate markets to create best-in-class training and education and will work collaboratively with all Nebraska MCOs and MLTC in planning and executing conferences, workshops, and webinars. [redacted] The needs of members and providers are always changing, so we understand the need for continual enhancements. We view provider training as a continuous, evolving process and a foundational element of our strategy to assure equitable, whole person care to our members.

Provider Advisory Committee

We regularly obtain provider feedback on our processes and procedures through various committee meetings and interactions, including our PAC meetings, which are hosted by our PE team, and led by our Chief Medical Officer on a quarterly basis. Providers are also invited along with members and community-based organizations to participate in the quarterly Member Advisory Committee meetings to provide feedback. Additionally, we hold quarterly peer-to-peer discussions between providers and our Medical Directors. All feedback and input are reported through the QAPIC for oversight.

Healthy Blue's PAC conducts quarterly meetings with providers to get feedback on our plan, processes, and challenges providers face. We encourage suggestions to improve programs for providers and members. The PAC offers an opportunity to share bidirectional information, allowing Healthy Blue to share upcoming initiatives, digital tools, and community resources with providers while gathering their feedback about programmatic roadmaps. Healthy Blue also leverages PAC meetings to conduct surveys among providers to gather feedback on topics such as our VBP models, whole person care approaches, and delivery of care model improvements.

The PAC will also provide an opportunity for Healthy Blue to collect information regarding the performance of our dental subcontractor, Liberty Dental Plan, with feedback and insight into several areas, including:

- The overall opinion of Liberty Dental Plan in the State
- How the program is running
- Improvements that can be made to the administration of the program
- Identification of benefits that need review/change

[redacted]

- Additional outreach possibilities for overall oral health
- Member education topics

Complaints, Grievances, and Appeals

We will routinely monitor complaints, grievance, and appeals data to help us gauge satisfaction with our service delivery, as well as monitor and resolve issues. This data will also help us support access to efficient and evidence-based care; detect underutilization; identify unnecessary, wasteful, or fraudulent practices; and implement and evaluate improvements. We use this information to identify providers for additional education as well as areas in which we may consider modifying policies based on feedback.

Provider Relationships

Our PE team establishes direct relationships with providers, allowing Healthy Blue to glean opportunities for improvement from their direct feedback. In addition to annual surveys, we will also offer providers the opportunity to fill out a satisfaction survey after each web-based, telephone, or in-person interaction with one of our PE Representative. PE Representatives conduct in-person, virtual, or telephone visits with individual providers on a regular basis. [redacted]

> *Our experience working with them over this past year has been overwhelmingly positive, which has led to improved patient care and outcomes. When questions come up, no matter the topic, we have been very pleased with the turnaround times for the answer. This includes billing and coding questions and claims. I have personally found the Healthy Blue website easy to navigate and helpful in locating the Nebraska Medicaid Preferred Drug List. Instead of the waiting games of prior authorizations and pre-approvals, this has saved my staff and me tremendous amounts of time as we try to provide our patients with appropriate medications.*
>
> **Benjamin Thayer, MD**
> BCH Gage County Medical Clinic
>
> NE_HH22_BenjaminThayer_2_TST_03

Provider Townhalls

Healthy Blue hosts provider townhalls quarterly. PE Representatives include event invitation links in all their emails and encourage providers to enroll. During a townhall, we provide information on high-performing network, available resources, and key information related to claims processing. All questions and comments are documented, and we follow up with providers after the presentation to assure their questions have been answered. ***Since July 2021, 259 of our providers have attended Healthy Blue townhalls.***

Opening lines of communication and proactively addressing issues and concerns increases provider satisfaction, aids in retaining our current network, and entices out-of-network providers to join our network.

Implementing Quality Improvements

[redacted]

Provider Feedback Facilitates Network Enhancements

[redacted]

[redacted]

Stakeholder Listening Sessions

Healthy Blue has also participated in seven stakeholder listening sessions convened by MLTC, five in-person listening sessions, and two virtual sessions. Each session providers brought 5 to 10 issues to light, including claims payment issues, outstanding accounts receivables, and credentialing delays. There were some additional concerns raised around the responsiveness of PE Representatives, catalyzing the implementation of the PERM model in the first quarter of 2022 that requires PE Representatives to respond within 48 hours. BH providers expressed concern that MCO staff were not adequately trained in BH issues. To assure that our staff is comprehensively prepared for issues related to BH, all BH UM reviewers are licensed clinicians and receive extensive training on a variety of BH topics, such as:

- Behavioral Health: Treating the Whole Person
- BH Service Grids Training
- MCG® Care Guidelines 25th Edition: Behavioral Health
- Sensitive Services: Substance Use Disorder Guide

Additional Examples of Addressing Provider Concerns. [redacted]

No. 49

Healthy Blue is committed to delivering all covered benefits by focusing on the highest level of service and clinical quality outcomes possible. Our service and administration delivery model leverages a number of trusted subcontracting partners that have delivered superior results-oriented track records, and outcomes. In the pages that follow, we have provided operational overviews that outline the services each proposed subcontractor will provide along with additional information that addresses each organization's experience and background, size, breadth of operating history with Healthy Blue, our parent company and affiliates, and resources of each organization to give DHHS the confidence that each subcontractor we partner with meets all applicable requirements laid out in RFP Section K.

When viewed in entirety, these overviews offer a complete Nebraska subcontractor engagement picture that clearly identifies each organization and their role and responsibilities specific to service delivery and/or administrative support for Nebraskans enrolled as Healthy Blue members. For ease of review, subcontractors are divided into direct member support, and Healthy Blue administrative service and support categories.

Consistent with MLTC subcontractor review and authorization requirements outlined in SOW section K.2, Healthy Blue will submit all subcontracts for approval at least 120 calendar days prior to implementation.

The first grouping of subcontractors, identified next, includes subcontractors that provide direct health care services to Healthy Blue members:

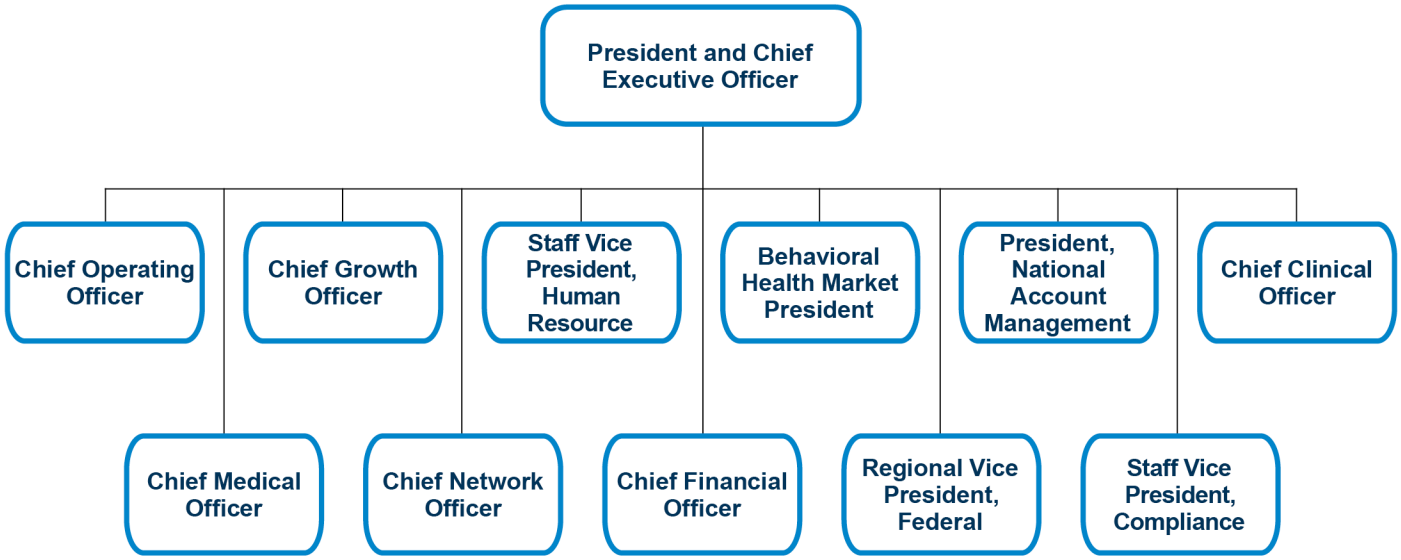
- Beacon Health Options, Inc.
- HN1 Therapy Network, LLC
- IngenioRx, Inc.
- LIBERTY Dental Plan Corporation
- ModivCare Solutions, LLC
- Teladoc Health, Inc. (dba Livongo Health)
- Superior Vision Benefit Management, Inc.

Beacon Health Options, Inc.	
Description of role in project, Size, Resources and Corporate Background	Beacon Health Options, Inc. (Beacon) serves as a turnkey behavioral health (BH) and substance use disorder (SUD) solution for members. Beacon provides BH/SUD, managed care clinical and quality solutions, care coordination, and BH/SUD program/claims administration. Beacon is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — full accreditation for exceptional clinical results and the delivery of quality services ▪ URAC — accreditation focused on quality outcomes and related oversight processes and procedures ▪ CMS — Quality Improvement Organization (QIO) designation — certifies use of clinical staff trained in care and service delivery along with beneficiary support and facilitation practices Beacon is headquartered in Boston with 70 locations across the US;180 employer clients, including 43 Fortune 500 clients; 65 health plans serving commercial, Medicaid, and Exchange populations. Beacon has programs serving Medicaid and other public section populations in 25 states and Washington, DC.
Date company formed, established, or created	Beacon was incorporated in the Commonwealth of Virginia on April 6, 1987.
Ownership structure	Elevance Health, Inc. (previously known as Anthem, Inc.) is the ultimate parent company of Beacon Health Options, Inc. Beacon Health Options, Inc. is a wholly owned subsidiary of FHC Health Systems, Inc., which is a wholly owned subsidiary of Beacon Health Vista Parent, Inc., which is a wholly owned subsidiary of Beacon Health Options Holdco, Inc., which is a wholly owned subsidiary of BVO Holdings, LLC, which is a wholly owned subsidiary of Elevance Health, Inc., a publicly traded company.
Total number of employees	Beacon has 3,700 employees.
Services provided in other states	Beacon currently provides services to our affiliates in one Medicaid Market. Beacon is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	200 State Street, Suite 302, Boston, MA 02109

See Figure V.K.49-1. Organizational Chart — Beacon Health Options, Inc. on the page that follows

Figure V.K.49-1. Organizational Chart — Beacon Health Options, Inc.

Beacon Health Options, Inc. Organizational Chart



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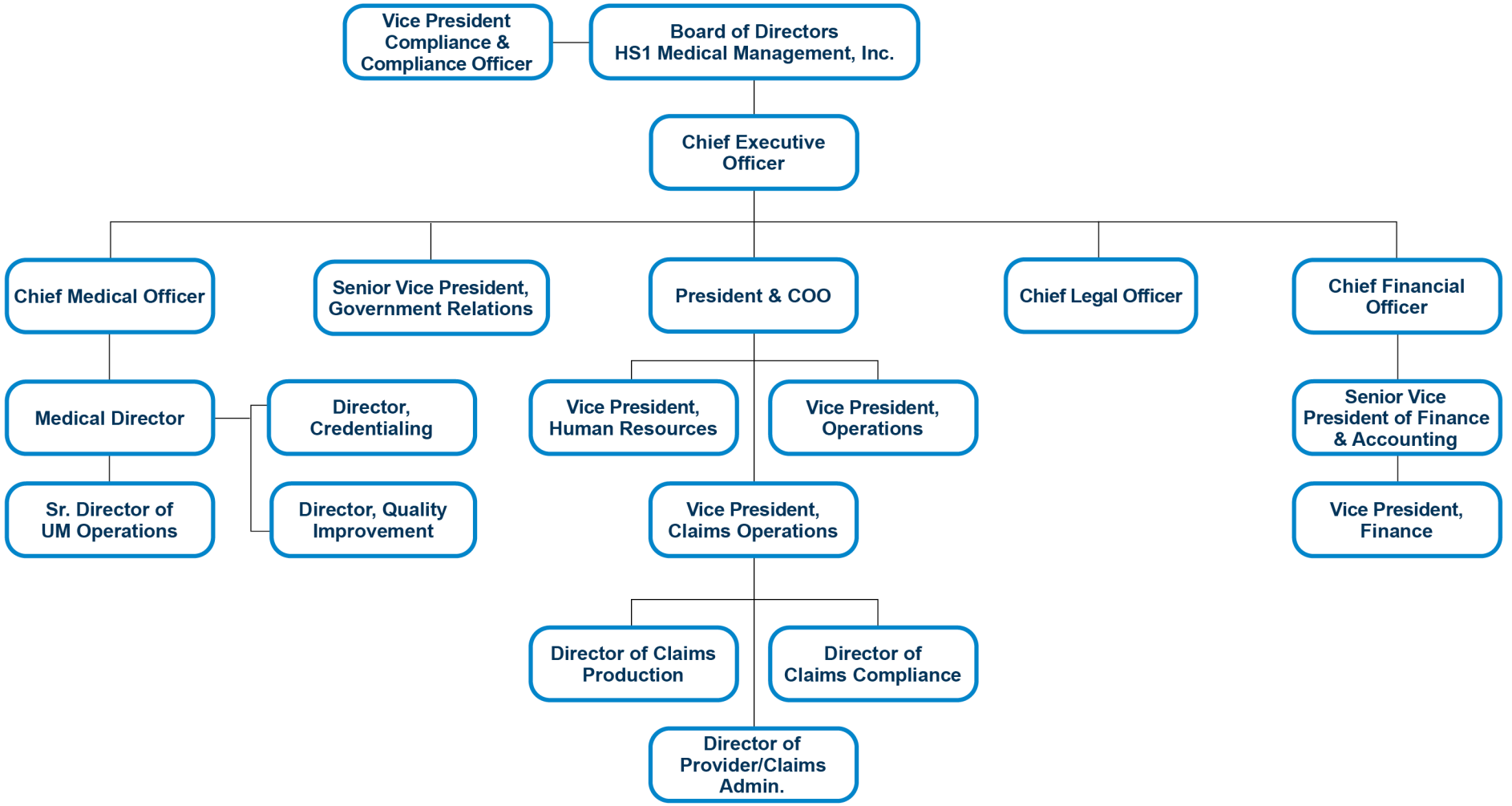
HN1 Therapy Network, LLC	
Description of role in project, Size, Resources and Corporate Background	HN1 Therapy Network, LLC (HN1) serves as a turnkey solution for professional outpatient physical therapy (PT), speech therapy (ST), and occupational therapy (OT) with responsibility for recruiting, contracting, and managing the PT, OT, and ST provider network; credentialing providers; process and paying claims; and performing utilization management. HN1 is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for exceptional credentialing and utilization management ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE System and Organization Controls (SOC) 1, Type 2 Standard certification — readiness recognition HN1 operates in several states and Puerto Rico covering upwards of 5,000,000 lives in total. In each state in which they operate, HN1 has a robust government relations presence. An important feature of their service model is on-the-ground Network Directors and Provider Experience Representatives. HN1 works with eight Medicaid plans, with their first engagement starting more than 15 years ago. In addition to our parent company, HN1 has working relationships with several national Medicaid organizations including Centene, Aetna, Humana, and Molina.
Date company formed, established, or created	HN1 was founded in 1999 in the State of Florida.
Ownership structure	HN1 Therapy Network, LLC is a private, limited liability company (LLC) affiliated with Health Network One, Inc., an accredited third-party administrator.
Total number of employees	HN1 has 265 employees.
Services provided in other states	HN1 Therapy Network provides services to our affiliates in two Medicaid Markets and Puerto Rico. HN1 is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	2001 South Andrews Avenue, Fort Lauderdale, FL 33316

See Figure V.K.49-2. Organizational Chart — HN1 Therapy Network, LLC on the page that follows

Figure V.K.49-2. Organizational Chart — HN1 Therapy Network, LLC.

HN1 Therapy Network, LLC Organizational Chart

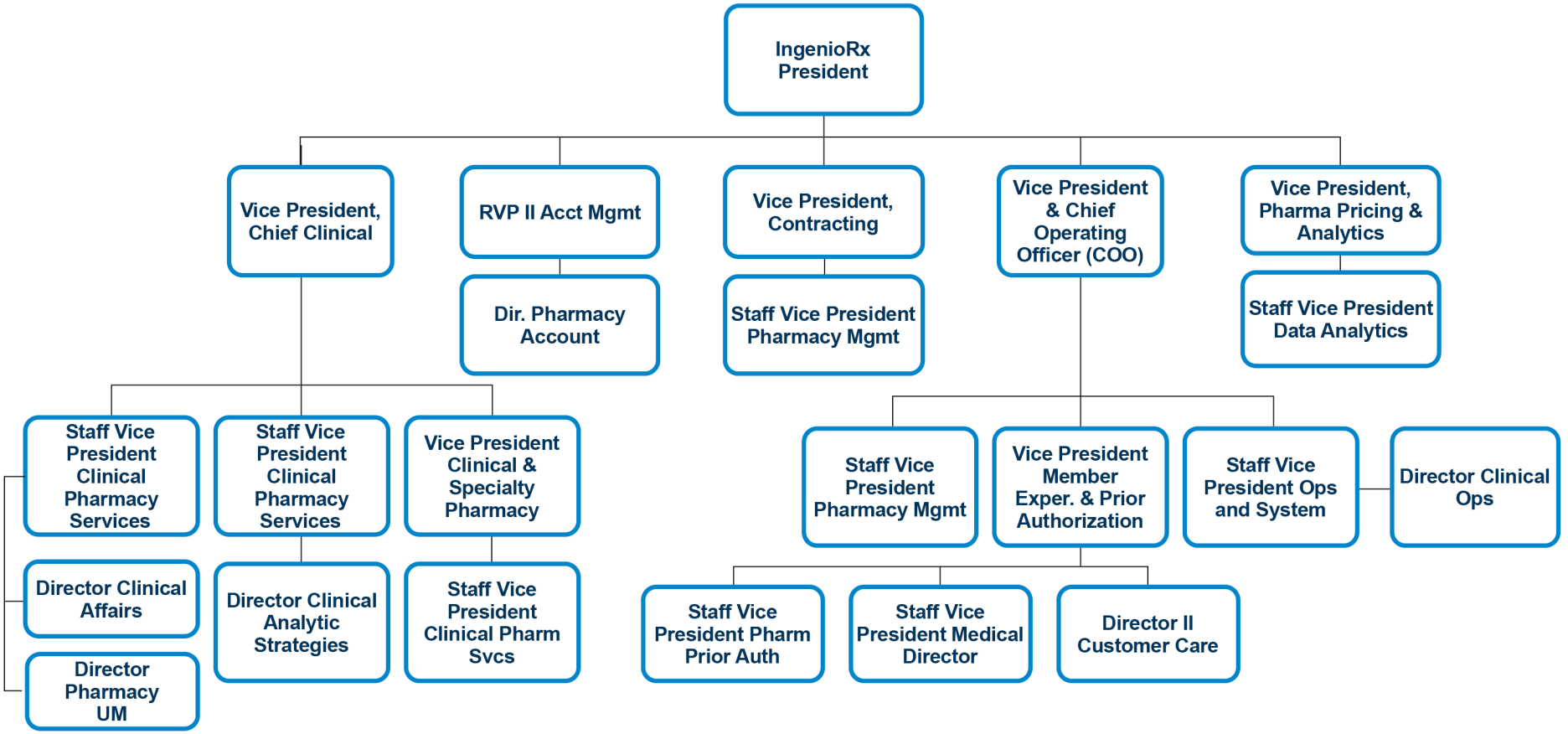


IngenioRx, Inc.	
Description of role in project, Size, Resources and Corporate Background	IngenioRx, Inc. (IngenioRx) provides Healthy Blue with Pharmacy Benefits Management (PBM) services, which include: ▪ Claim adjudication, including Prospective Drug Utilization Review ▪ Pharmacy network management ▪ 24/7/365 Member Services Call Center ▪ Prior authorizations ▪ Reporting and analytical support ▪ Clinical services and clinical quality programs, including medication therapy management ▪ Formulary management and State preferred drug list (PDL) IngenioRx, Inc. began providing PBM services to Healthy Blue members on January 1, 2021 with prior approval from DHHS. IngenioRx, is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ Joint Commission on Accreditation of Healthcare Organizations accredited for specialty pharmacy operations ▪ URAC — full accreditation focused on quality practices for Pharmacy Benefit Management and mail service pharmacy IngenioRx's history and experience providing PBM services spans multiple decades. The legacy companies of IngenioRx, NextRx, Anthem Pharmacy Solutions, and our parent company, Elevance Health (previously known as Anthem, Inc.), has provided members with pharmacy services since 1989. IngenioRx currently manages the pharmacy benefit in 16 Medicaid markets for more than 6.7 million Medicaid members, including managing pharmacy and medical injectable prior authorizations as well as managing clinical programs to improve member adherence, reduce polypharmacy, close gaps in care, and support a variety of HEDIS® measures. Of these markets, IngenioRx manages to the State PDL in seven Medicaid markets. IngenioRx also oversees medical drug management, including medical drug prior authorization for affiliate Plans in six additional Medicaid markets where IngenioRx does not manage the pharmacy benefit (for example, the pharmacy benefit is carved out to the State).
Date company formed, established, or created	IngenioRx was founded in Indiana on October 4, 2017.
Ownership structure	Elevance Health, Inc. is the ultimate parent company of IngenioRx, Inc. IngenioRx is a wholly owned subsidiary of DBG Holdings, Inc., which is a wholly owned subsidiary of Elevance Health, Inc., a publicly traded company.
Total number of employees	IngenioRx has more than 2,000 employees.
Services provided in other states	IngenioRx provides services in 22 Medicaid markets including the State of Nebraska.
Physical location	450 Headquarters Plaza, East Tower, 7th Floor, Morristown, NJ 07960

See Figure V.K.49-3. Organizational Chart — IngenioRx, Inc. on the page that follows

Figure V.K.49-3. Organizational Chart — IngenioRx, Inc.

IngenioRx, Inc. Organizational Chart

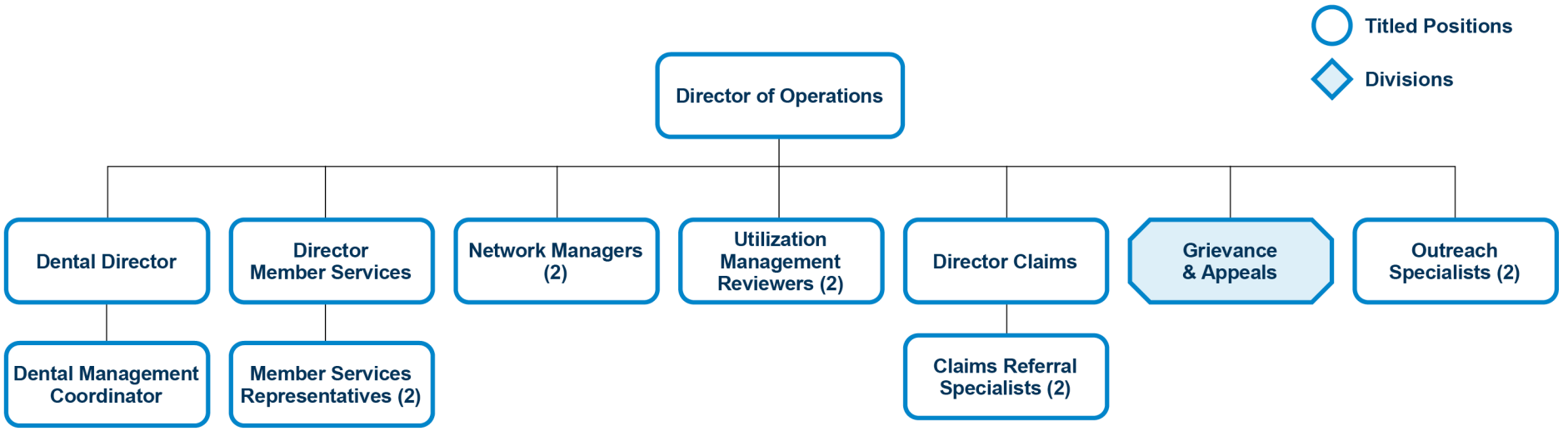


LIBERTY Dental Plan Corporation	
Description of role in project, Size, Resources and Corporate Background	LIBERTY Dental Plan Corporation (LIBERTY Dental) will be managing the dental benefit on behalf of Healthy Blue, which encompasses supporting a range of functions, including utilization management, claims processing, network management, provider credentialing/recredentialing, member and provider call centers services, and member education and outreach. LIBERTY Dental is committed to maintaining industry-recognized accreditations or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for credentialing and utilization management ▪ URAC — accreditation quality management oversight and outcomes LIBERTY Dental serves more than 6.1 million lives, which includes nearly 4 million Medicaid members, 1.6 million Medicare members, and 582,000 Commercial and Exchange members. LIBERTY Dental focuses on serving low-income and vulnerable populations through government programs, including Medicaid and CHIP. They began providing Medicaid dental benefit administration services in 2005 to provide services to nearly 4 million lives across six states. LIBERTY Dental also maintains a national network of providers that currently provide services to Elevance Health's Medicare Advantage members in all 50 states.
Date company formed, established, or created	LIBERTY Dental was incorporated in Delaware in 2007.
Ownership structure	LIBERTY Dental Plan Corporation is a privately held company with an Agreement to pursue a capitalization initiative with a private equity firm, Welsh, Carson, Anderson & Stowe (majority investor) and Elevance Health, Inc. (minority investor). The transaction has not closed at the time of RFP submission but is expected to close by the end of 2022.
Total number of employees	LIBERTY Dental has 1,213 employees.
Services provided in other states	LIBERTY Dental currently provides services to our affiliates in two Medicaid Markets. LIBERTY Dental is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	340 Commerce, Suite 100, Irvine, CA 92602

See Figure V.K.49-4. Organizational Chart — LIBERTY Dental Plan Corporation on the page that follows

Figure V.K.49-4. Organizational Chart — LIBERTY Dental Plan Corporation.

LIBERTY Dental Plan Corporation Organizational Chart



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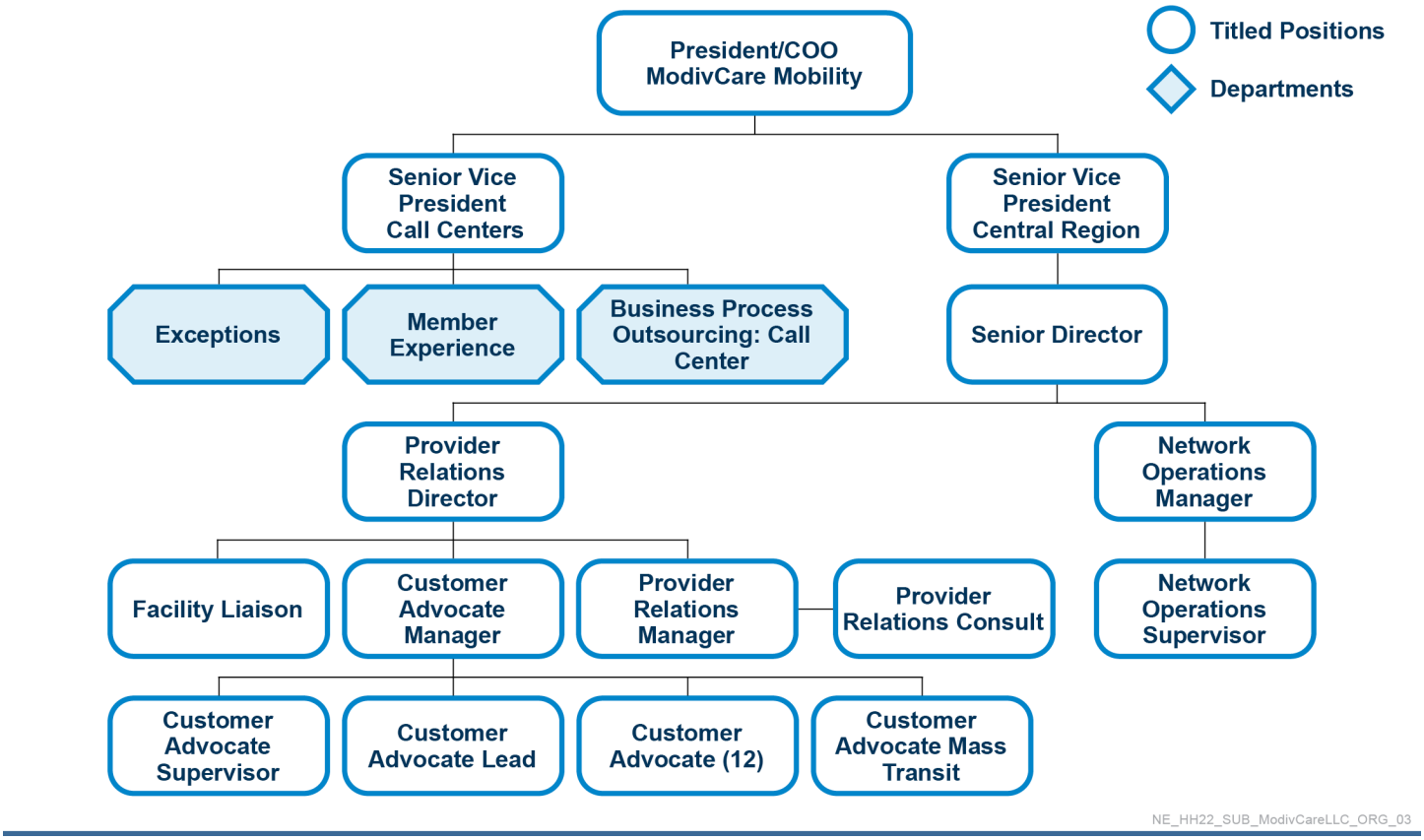
ModivCare Solutions, LLC	
Description of role in project, Size, Resources and Corporate Background	ModivCare Solutions, LLC (ModivCare) will provide a turnkey Non-Emergency Transportation (NET) and Non-Emergency Medical Transportation (NEMT) solution for Healthy Blue members. ModivCare will be responsible for managing all aspects of non-emergency medical and non-medical transportation benefits, which includes: ▪ Transportation network development, credentialing, and retention activities ▪ Member and provider call center services ▪ Tracking and documenting trips ▪ Verifying member eligibility and service coverage ▪ Scheduling and assigning authorized trips ▪ Collecting trip log data ▪ Claims reimbursement and encounter tracking and reporting ▪ Updates and reviews of provider data ModivCare has provided services to Nebraska Medicaid members for more than two years. In that time, they have developed a high-quality, PSC-compliant network comprised of 475 drivers. In 2021, ModivCare provided approximately 165,000 trips to Nebraska Medicaid members, 25,401 of those were for dialysis or chemotherapy. These trips were delivered with on on-time performance of 90%. Additionally, ModivCare exceeded call center service levels by answering 90% of calls within 30 seconds. ModivCare is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ URAC — accreditation of oversight processes and procedures ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Additionally, ModivCare is a nine-year award winner of the National Safety Council's Safety Award designating them as an organization with superior adherence to transportation related safety standards. ModivCare's integration with the health care community spans more than 35 years and is driven by a single goal: creating the best member experience. They use a full-brokerage NEMT model that operates in accordance with CMS guidelines. ModivCare currently partners with 15 state Medicaid agencies and 30 MCOs across the country to manage more than 340 unique transportation service programs. Their service reach and network provide coverage in all 50 states and Washington, DC. Collectively, they provider more than 48 million trips each year to the 24.5 million Medicaid lives they serve.
Date company formed, established, or created	ModivCare (formerly known as LogistiCare) was founded in Delaware in 1986.
Ownership structure	ModivCare Solutions, LLC is a wholly owned subsidiary of ModivCare Inc., a publicly traded corporation exchanging under NASDAQ Stock Code MODV.
Total number of employees	ModivCare has 3,500 employees dedicated to the provision of NET and NEMT services.
Services provided in other states	ModivCare provides services to our affiliates in five Medicaid Markets. ModivCare is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	6900 Layton Avenue, 12th Floor, Denver, CO 80237

See Figure V.K.49-5. Organizational Chart — ModivCare Solutions, LLC on the page that follows

Figure V.K.49-5. Organizational Chart — ModivCare Solutions, LLC.

ModivCare Solutions, LLC Organizational Chart

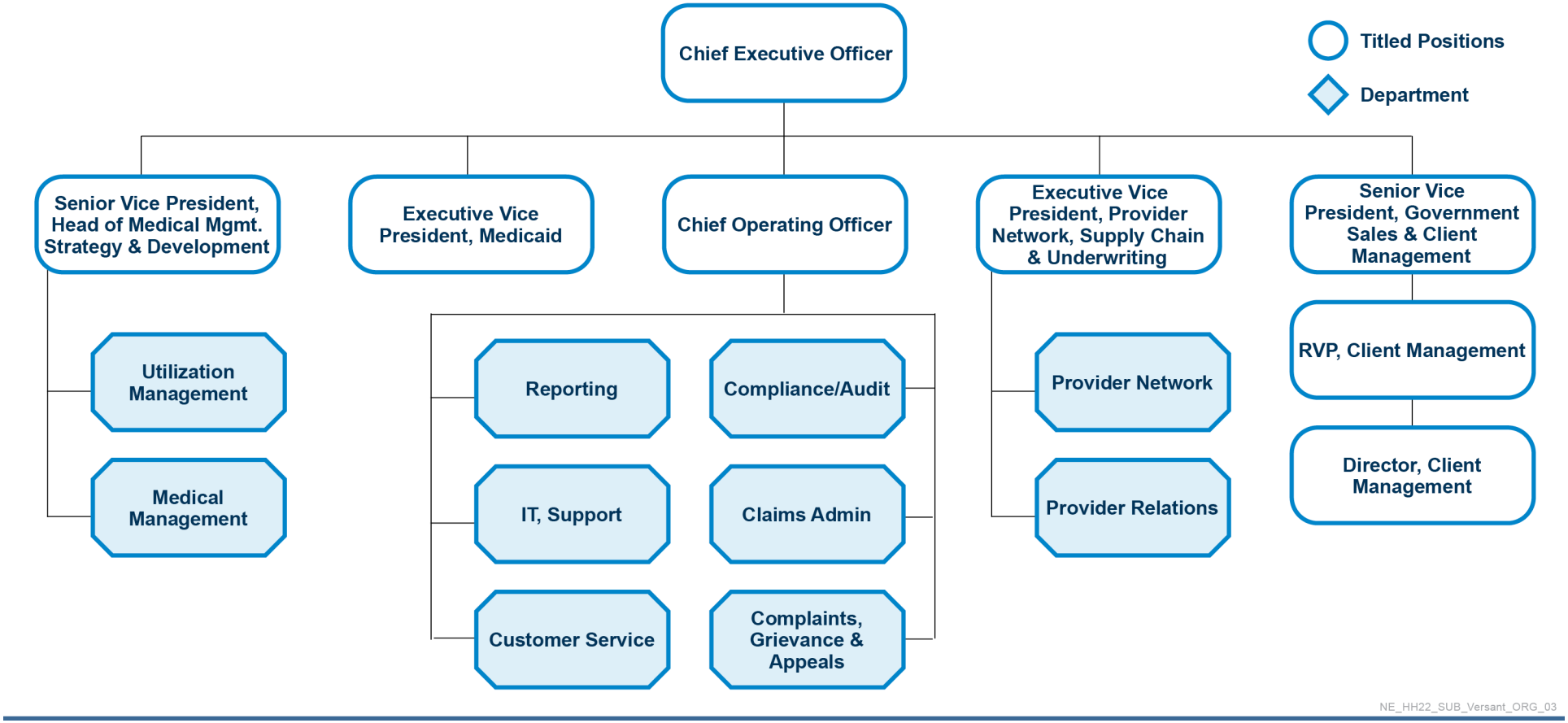


Superior Vision Benefit Management, Inc.	
Description of role in project, Size, Resources and Corporate Background	Superior Vision Benefit Management, Inc. (Superior Vision) will be managing the vision benefit on behalf of Healthy Blue, which encompasses supporting a range of functions, including utilization management, claims processing, network management, provider credentialing/recredentialing, and member and provider call center services. Superior Vision is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for utilization management ▪ URAC — accreditation focused on quality outcomes and related oversight processes and procedures ▪ SSAE SOC 1, Type 1 Standard certification — adequate process controls in place ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Superior's parent, Versant Health, has specialized in public sector programs since 1994. Their customers include commercial groups, individuals, and health plans that serve government-sponsored programs such as Medicare Advantage, Medicaid, and CHIP. For nearly 30 years, Versant has delivered a full continuum of vision care services within one integrated delivery system that places the members' needs first. Versant Health provides vision services to more than 18 million government health plan members, including 16.8 million Medicaid, 210,000 D-SNP and MMP members, 1.2 million Medicare members, and 2.5 million ACA/CHIP members.
Date company formed, established, or created	Superior Vision was incorporated in 1990 in the State of New Jersey.
Ownership structure	Superior Vision Benefit Management, Inc. is a wholly owned indirect subsidiary of Superior Vision Services, Inc. and Versant Health, Inc., which is a wholly owned subsidiary of MetLife, Inc.
Total number of employees	Superior Vision has 361 employees and Versant Health has 878 employees.
Services provided in other states	Superior currently provides services to our affiliates in eight Medicaid Market. Superior Vision is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	881 Elkridge Landing Road, Suite 300, Baltimore, MD 21090

See Figure V.K.49-6. Organizational Chart — Superior Vision Benefit Management, Inc. on the page that follows

Figure V.K.49-6. Organizational Chart — Superior Vision Benefit Management, Inc.

Superior Vision Benefit Management, Inc. Organizational Chart

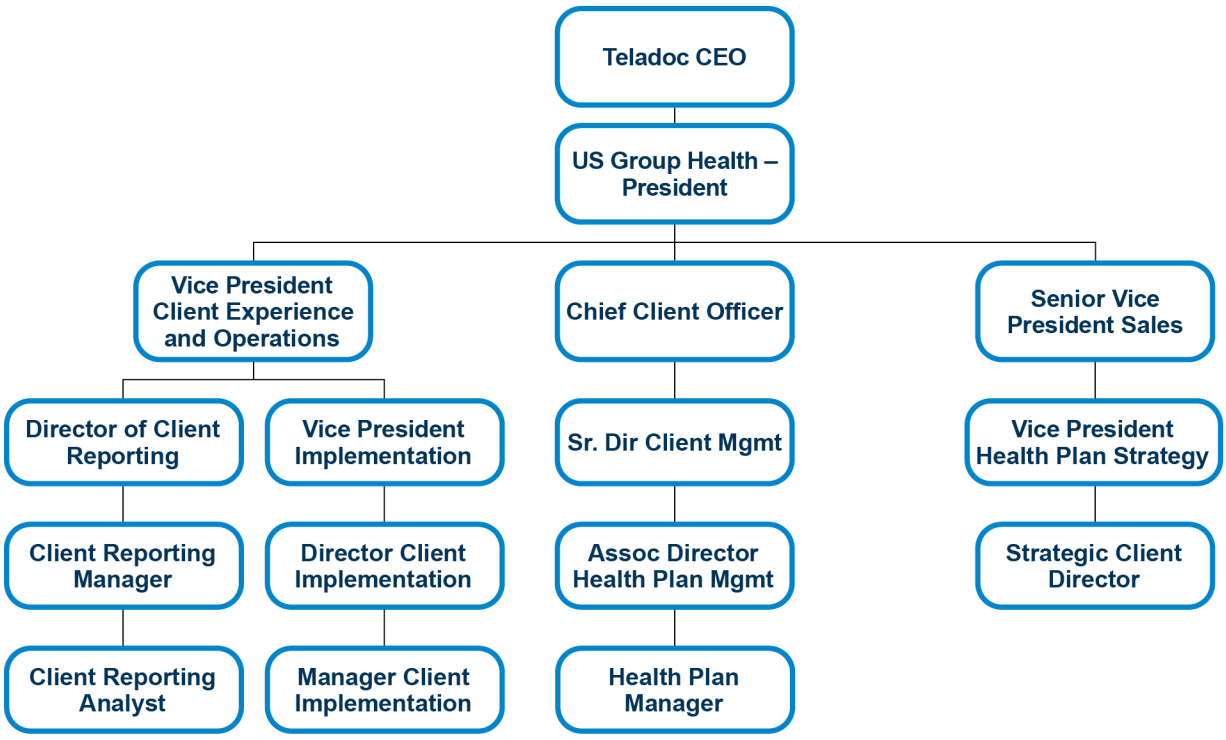


Teladoc Health, Inc. (dba Livongo Health)	
Description of role in project, Size, Resources and Corporate Background	Teladoc Health, Inc. (dba Livongo Health) will offer diabetes chronic care management support services to Healthy Blue members. The diabetes management program includes: ▪ A smart cellular enabled glucometer device capable of communicating readings to the supplier mobile application installed on the member's smart phone and adequate supplies each month ▪ Submission of blood glucose data obtained by data enabled meters, displayed directly on a device and transmitted to participants; first line educational health coaching and non-medical acute response to alerts generated from the use of the glucometer device ▪ Participant access to 24/7 on-call support ▪ Diabetes education provided by diabetes educators certified as Certified Diabetes Care and Education Specialist (CDCES®) by the National Certification Board for Diabetes Educators ▪ Web portal integration with tips of the day Teladoc is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for credentialing ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 1, Type 1 Standard certification — adequate process controls in place ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Teladoc Health services span more than 450 medical subspecialties across more than 175 countries and 40 languages. On average, more than 30,000 virtual visits are conducted using Teladoc Health's services each day. In 2021, they delivered more than 15 million visits/encounters. Teladoc Health serves more than 150 US health plans and provides virtual care services across commercial, Medicare, and Medicaid lines of business. They conduct virtual care visits for Medicare and Medicaid members in all 50 U.S. states, plus Washington, DC. Teladoc Health has significant experience with Medicaid programs and serving the unique needs of Medicaid members. More than 11 million Medicaid members have access to Teladoc Health services across 50+ government health plan partners.
Date company formed, established, or created	Teladoc Health, Inc. initially incorporated as a privately owned, venture-backed company in 2002. In July of 2015, Teladoc Health, a Delaware corporation, became a publicly traded company on the NYSE (TDOC).
Ownership structure	Teladoc Health is a publicly traded company.
Total number of employees	Teladoc Health has 5,100 employees.
Services provided in other states	Teladoc Health currently provides services to our affiliates in two Medicaid Markets. Teladoc Health is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	2 Manhattanville Rd, Suite 203, Purchase, NY 10577

See Figure V.K.49-7. Organizational Chart — Teladoc Health, Inc. (dba Livongo Health) on the page that follows

Figure V.K.49-7. Organizational Chart — Teladoc Health, Inc. (dba Livongo Health).

Teladoc Health, Inc. (dba Livongo Health) Organizational Chart



The second grouping of subcontractors includes entities providing administrative services and support to Healthy Blue:

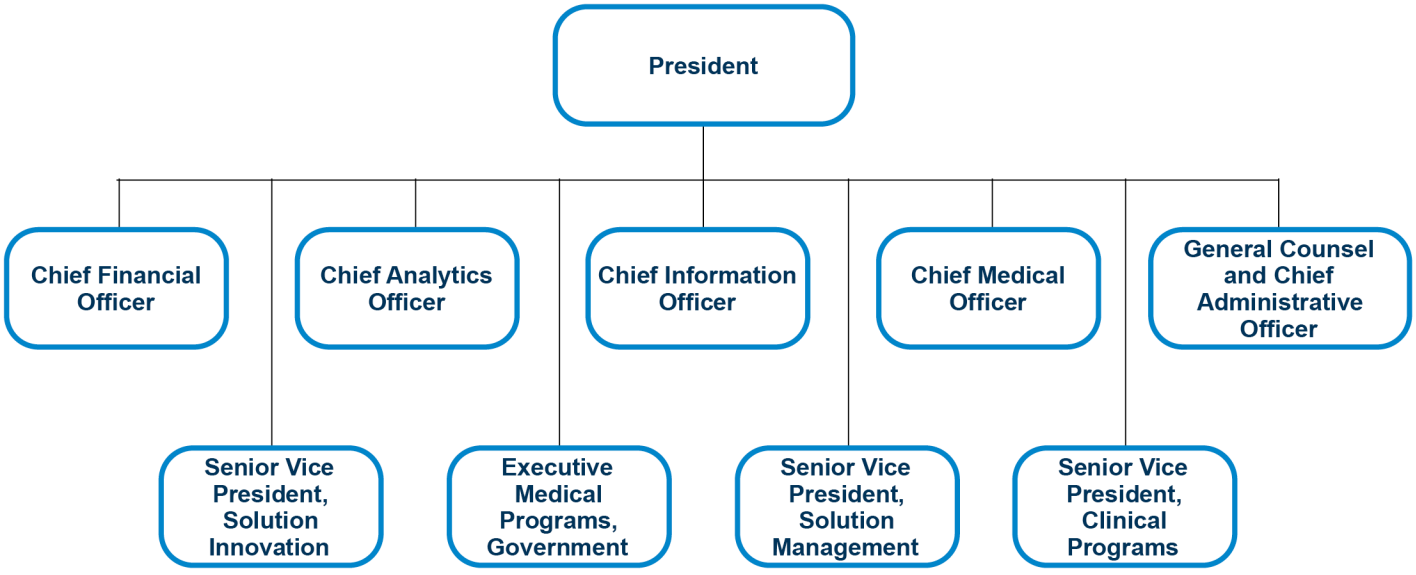
- American Imaging Management, Inc. (dba AIM Specialty Health)
- American Well (dba Amwell)
- Aunt Bertha, a Public Benefit Corporation (dba findhelp)
- Availity, LLC
- Centauri Health Solutions, Inc.
- Center for the Study of Services, Inc.
- Clarity Software Solutions, Inc.
- ColorArt, LLC
- Conduent Credit Balance Solutions, LLC
- Conduent, Inc.
- CERiS, Inc.
- Cotiviti, Inc.
- Council for Affordable Quality Healthcare, Inc. (CAQH)
- CQ fluency, Inc.
- CulturaLink, LLC
- CyraCom International, Inc.
- Direct Technologies, Inc.
- Elevance Health, Inc. (Elevance Health)
- Health Management Systems, Inc.
- Lamont, Harley & Associates, Inc.
- Language Services Associates, Inc.
- Lone Star Consulting Services, LLC (dba MES Peer Review Services)
- Meridian Resource Company, LLC
- mPulse Mobile, Inc. (fka CrowdCircle)
- OneTouchPoint Corp.
- Preferred Direct Marketing Services, Inc.
- Prest & Associates, LLC
- R.R. Donnelley & Sons Company
- The Dieringer Research Group, Inc.

American Imaging Management, Inc. (dba AIM Specialty Health)	
Description of role in project, Size, Resources and Corporate Background	American Imaging Management, Inc. (dba AIM Specialty Health) (AIM) will continue to provide utilization management prior authorization services to Healthy Blue spanning the following treatment areas: ▪ Radiology ▪ Expanded cardiology ▪ Radiation oncology ▪ Medical oncology ▪ Genetic testing ▪ Sleep therapy ▪ Musculoskeletal Activities will include clinical appropriateness review, member engagement, value-based purchasing alignment, clinical setting optimization, provider engagement, and claims payment support services. AIM is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — full accreditation for exceptional clinical results and the delivery of quality services ▪ URAC — accreditation focused on quality outcomes and related oversight processes and procedures ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ International Organization for Standardization (ISO) ○ 27001:2013 — systems and data integrity certification AIM provides utilization management services touching more than 68 million individuals throughout the 50 states and Washington, DC. Medicaid, Medicare, and commercial health plans use AIM's utilization management services. AIM provides utilization management services to 22 Medicaid health plans throughout the country for multiple service solutions, including but not limited to radiology, cardiology, radiation oncology, medical oncology, pain management, and sleep.
Date company formed, established, or created	AIM was founded in Illinois in 1989.
Ownership structure	Elevance Health, Inc. is the ultimate parent company of American Imaging Management, Inc. American Imaging Management, Inc. is a wholly owned subsidiary of Imaging Management Holdings, LLC, which is a wholly owned subsidiary of ATH Holding Company, LLC, which is a wholly owned subsidiary of Elevance Health, Inc., a publicly traded company.
Total number of employees	AIM has 1,828 employees.
Services provided in other states	AIM currently provides services to our affiliates in 20 Medicaid Markets including the State of Nebraska.
Physical location	8600 West Bryn Mawr Ave, South Tower, Suite 800, Chicago, IL 60631

See Figure V.K.49-8. Organizational Chart — AIM Specialty Health on the page that follows

Figure V.K.49-8. Organizational Chart — American Imaging Management, Inc. dba AIM Specialty Health.

American Imaging Management, Inc., d/b/a AIM Specialty Health Organizational Chart



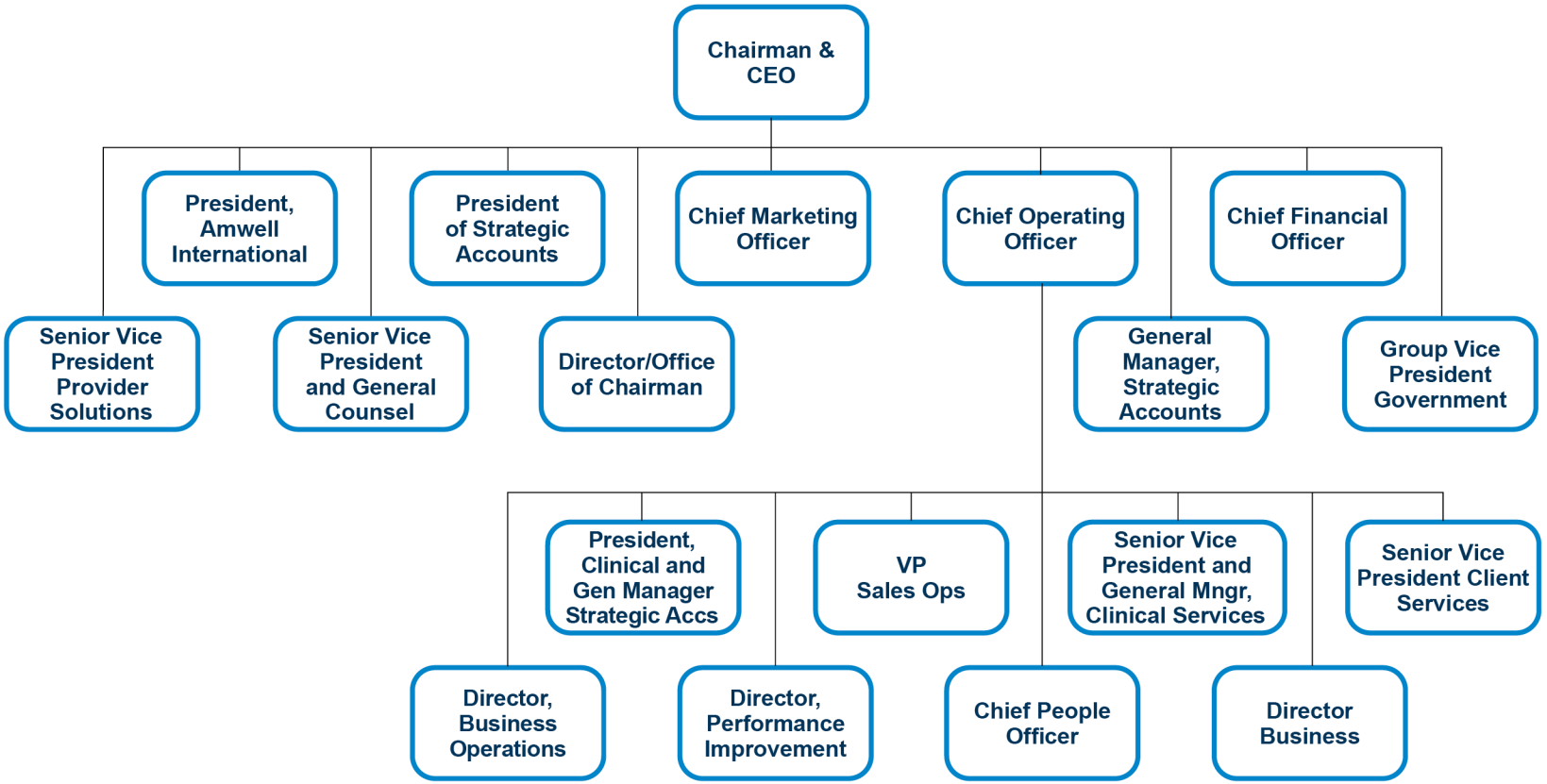
NE_HH22_SUB_AIMSpecialtyHealth_ORG_04

American Well (dba Amwell)	
Description of role in project, Size, Resources and Corporate Background	American Well (dba Amwell) provides Healthy Blue members 24/7 Urgent Care telehealth services and appointment-based BH services. On the Amwell platform, our members can connect with the first available provider or the provider of their choosing, as well as schedule a consultation for the day and time that works best for them, using their preferred medium: web, mobile, or telephone. Amwell equips our providers with full documentation capabilities including configurable note templates, ICD and CPT® coding, electronic prescribing, eligibility and claims checking, referral management, and visit summary exporting to document the clinical encounter. Amwell is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for credentialing and recredentialing processes ▪ URAC — accreditation for telemedicine program ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Amwell partners with some of the nation's largest health plans, health systems, brokers, retailers, and employers. Amwell serves more than 150 health systems and 2,000 hospitals nationwide, as well as accountable care organizations and population health and occupational health groups. Amwell has more than 55 health plan customers, serving commercial, exchange, Medicaid, and Medicare Advantage populations. Their partners include Cigna, UnitedHealthcare, and more than 30 independent Blue Cross Blue Shield plans. Amwell serves more than 36,000 employers, most of which are through health plan relationships. More than 80 million people have covered access to the Amwell platform through their health plan or employer.
Date company formed, established, or created	Amwell was founded as a Delaware Corporation in 2006.
Ownership structure	American Well (dba Amwell) is a publicly traded company listed on the New York Stock Exchange.
Total number of employees	Amwell has 1,035 employees.
Services provided in other states	Amwell currently provides services to our affiliates in 14 Medicaid Markets, including the State of Nebraska, with two additional markets slated to go-live in the coming months.
Physical location	75 State Street, Floor 26, Boston, MA 02109

See Figure V.K.49-9. Organizational Chart — American Well (dba Amwell) on the page that follows

Figure V.K.49-9. Organizational Chart — American Well (dba Amwell).

American Well (dba Amwell) Organizational Chart

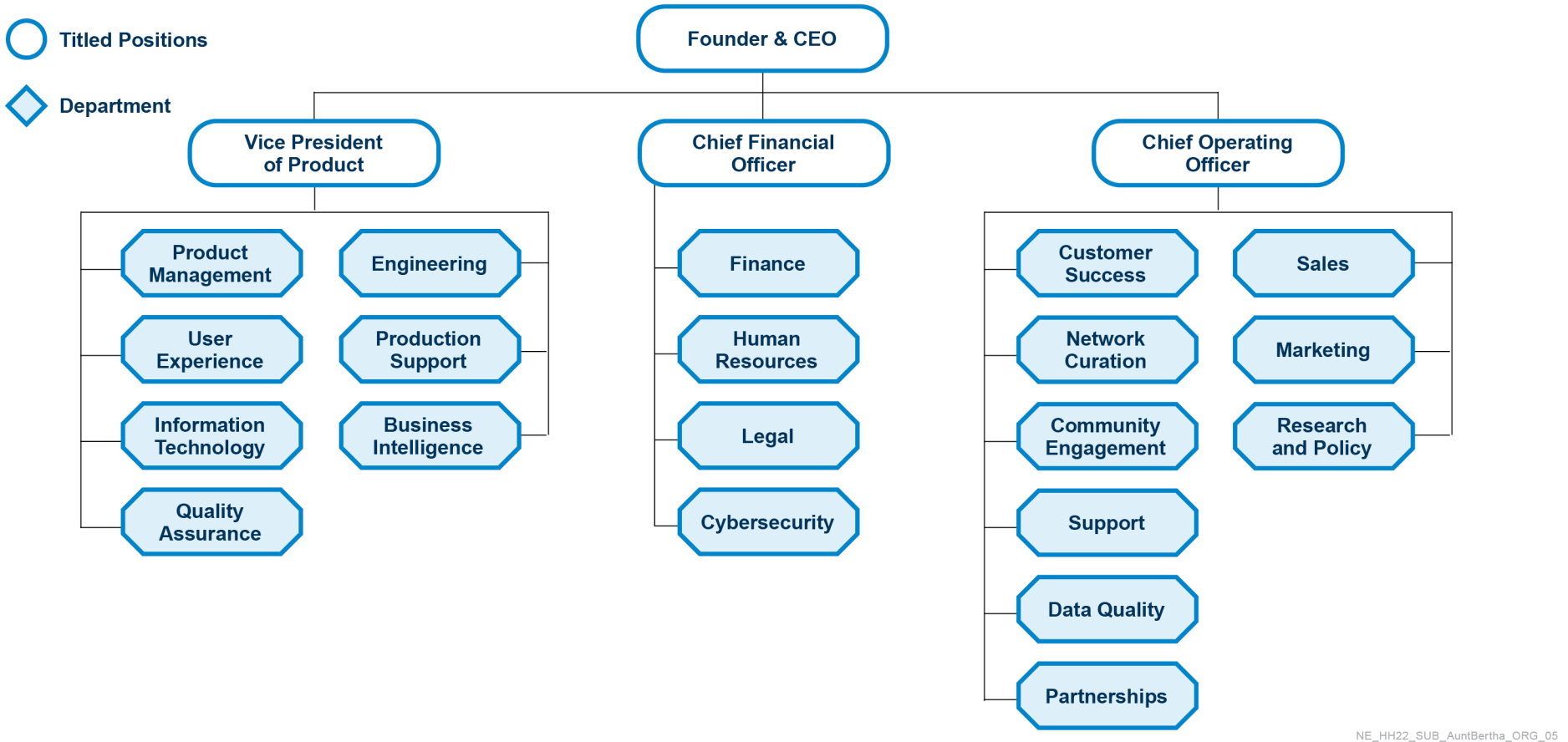


Aunt Bertha, a Public Benefit Corporation (dba findhelp)	
Description of role in project, Size, Resources and Corporate Background	Aunt Bertha, a Public Benefit Corporation (dba findhelp) connects Healthy Blue members to community supports and social care programs. Their activities also include public-private partnerships that address social determinants of health with a human-curated, Nebraska-specific resource platform. By way of example, their Marketplace functionality connects members to community-based organizations (CBOs) focused on delivering food. Aunt Bertha is already helping Nebraskans locate social care programs as upwards of 23,000 Nebraskans currently use their platform with 30% of all searches across the State related to housing. In the last year, Elevance Health's partnership with Aunt Bertha has resulted in 161,651 searches, nearly 5,000 users, and 6,615 referrals across our Medicaid business. Aunt Bertha is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met (including NIST 800-53 security controls) Aunt Bertha is uniquely positioned to work with Healthy Blue given our shared Nebraska-specific vision. Aunt Bertha's experience nationally includes nine of the 10 largest health plans, 100+ health plans total, 160+ health care organizations, nine health information exchanges, several government and education organizations, and many CBOs. Currently, Aunt Bertha works with the five largest Medicaid MCOs in the nation across 35 states (including Washington, DC). As the only social determinants of health network and referral subcontractor providing a free, public-facing website for all Americans, Aunt Bertha has jumped from 4 million users in mid-2020 to 11.5 million users today. Aunt Bertha is the largest closed loop referral network for social care services in the nation, with more than 170,000 electronic referrals being sent to CBOs monthly.
Date company formed, established, or created	Aunt Bertha was founded on August 31, 2010.
Ownership structure	Aunt Bertha is a privately held, public benefit corporation, certified as a B Corporation. As a Public Benefit Corporation, Aunt Bertha is required to consider the impact of its decisions on workers, customers, suppliers, the community, and the environment. Certification as a B Corporation is achieved by scoring well on an assessment of "social and environmental performance" and by showing that the company has integrated B Corp commitments into its company governing documents. Across the US, there are fewer than 2,000 Public Benefit Corporations.
Total number of employees	Aunt Bertha has 240 employees.
Services provided in other states	Aunt Bertha currently provides services to our affiliates in 23 Medicaid markets including Nebraska, with a 24th market scheduled to go-live in December of 2022.
Physical location	3616 Far West Blvd, Suite 117-454, Austin, TX 78731

See Figure V.K.49-10. Organizational Chart — Aunt Bertha, a Public Benefit Corporation (dba findhelp) on the page that follows

Figure V.K.49-10. Organizational Chart — Aunt Bertha, a Public Benefit Corporation (dba findhelp).

Aunt Bertha, a Public Benefit Corporation (dba findhelp) Organizational Chart

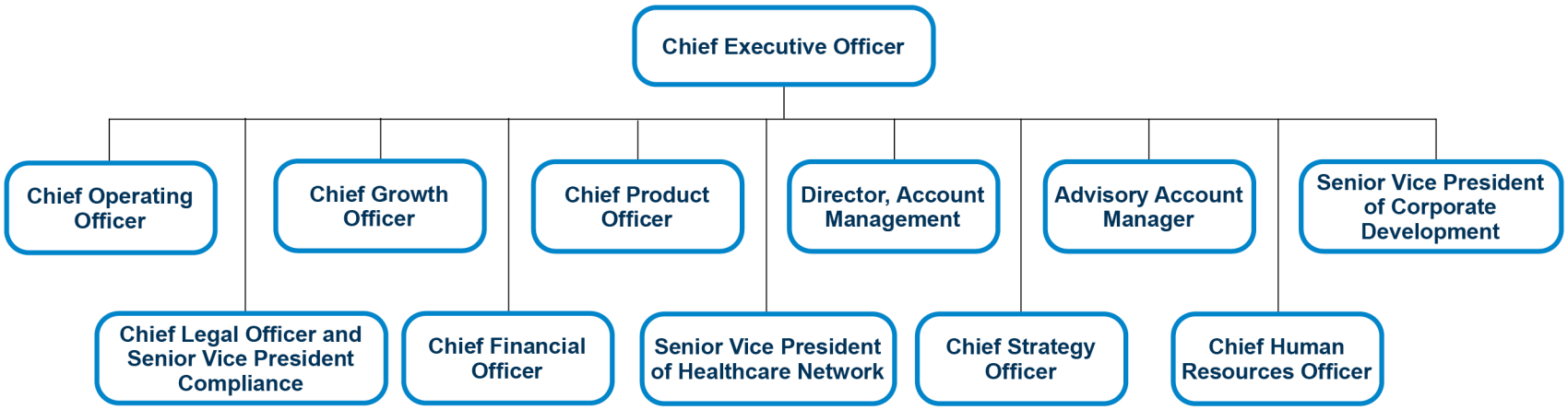


Availity, LLC	
Description of role in project, Size, Resources and Corporate Background	Availity, LLC will provide Healthy Blue both electronic data services (Availity EDI Gateway) and a provider engagement portal (Availity Essentials). The Availity EDI Gateway enables providers to exchange health care data with Healthy Blue. including HIPAA X12 standard and non-standard transactions such as: 837P, 837I, 837D, 270/271, 276/277, 278, Authorization Inquiry and response, 278 Authorization submission, changes, and void 835 ERA/remits. Currently, Availity provides services to two of the three plans serving Nebraska Medicaid recipients, delivering both electronic data services and a provider engagement portal. Based on year-to-date transactions, they expect providers' transactions to exceed five million in 2022 including but not limited to eligibility, claims submission, claims inquiry, authorization requests, and ERA/remittances. Availity is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ Electronic Healthcare Network Accreditation — accreditation of health care data exchange integrity and interoperability of data transfer ▪ CORE Phase I, II, III, and IV clearinghouse certification for CMS conformance and audit readiness Availity serves as one of the largest national EDI clearinghouses, transacting with nearly every payer. Availity's EDI Gateway is the exclusive transaction gateway for Elevance Health. Availity Essentials, a provider engagement portal, is the exclusive portal for Elevance Health. Availity provides services for health plans nationwide. Availity solutions make it easier for physician practices, hospitals, commercial health plans, and government payers to share the information needed to do business with each other, saving millions in administrative expenses every year. Availity Medicaid billing and other care related process experience includes eligibility, institutional and professional claims, claim status, and remittance transactions for Medicaid payers and processes. Availity processes roughly 16 million daily transactions, including Medicaid transactions in nearly every state.
Date company formed, established, or created	Availity was founded in 2001 as a Delaware corporation.
Ownership structure	Availity, LLC is a privately held company organized as a partnership between four of the nation's largest health plans and an international, world-leading life science investor, Elevance Health, Florida Blue, Health Care Service Corporation, Humana, and Novo Holdings. Elevance Health has 17.50% ownership interest in Availity.
Total number of employees	Availity has 1,450 employees.
Services provided in other states	Availity currently provides services to our affiliates in 24 Medicaid Markets including the State of Nebraska.
Physical location	5555 Gate Parkway, Suite 110, Jacksonville, FL 32256

See Figure V.K.49-11. Organizational Chart — Availity, LLC on the page that follows

Figure V.K.49-11. Organizational Chart — Availity, LLC.

Availity, LLC Organizational Chart



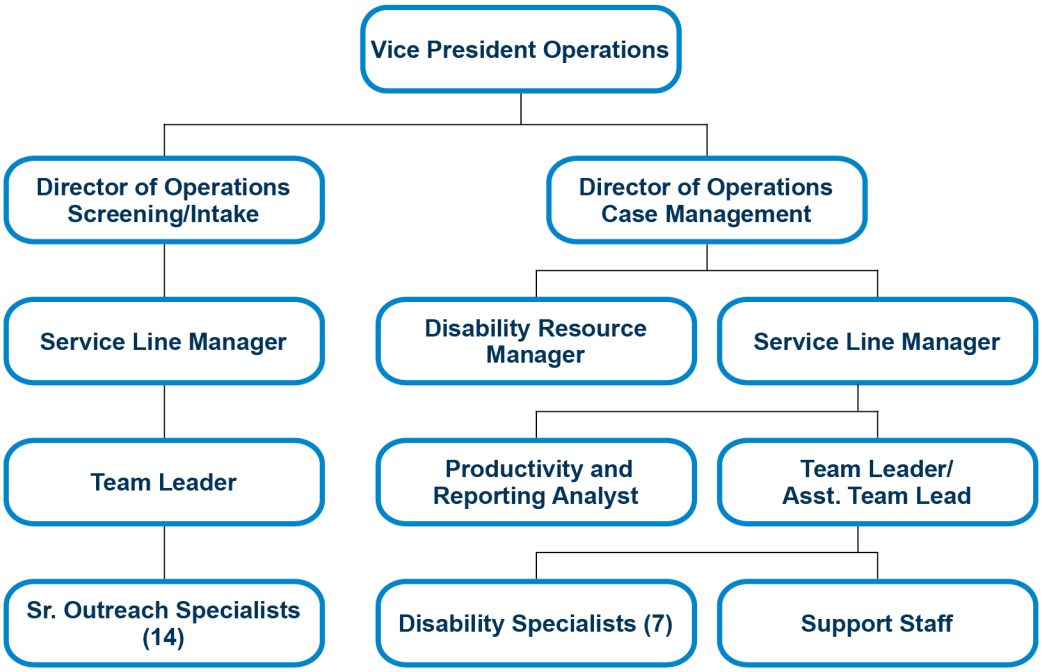
NE_HH22_SUB_AvailityLLC_ORG_04

Centauri Health Solutions, Inc.	
Description of role in project, Size, Resources and Corporate Background	Centauri Health Solutions, Inc. (Centauri) provides Healthy Blue its Best Benefits solution for the management of disability and eligibility services. Centauri mines membership and claims data (both medical and pharmacy) to identify members that are likely eligible for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Once identified, Centauri helps Healthy Blue members apply for SSI and SSDI. Centauri provides services to all current Nebraska Medicaid health plans. Since inception, Centauri has screened 796 Healthy Blue Members for SSI and SSDI eligibility, 156 of those members are actively engaged today. Centauri is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 1, Type 1 Standard certification — adequate process controls in place ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results ▪ SSAE SOC 3, Type 2 Standard certification — auditor's opinions, management assertion, and system description Centauri provides services to payors and providers across all health care programs, including Medicare, Medicaid, commercial, and exchange in 33 states and Washington, DC. Their disability and eligibility services support more than 43 million members nationwide. They currently serve more than 132 unique clients of which includes Medicaid and Medicare Advantage health plans from across the nation.
Date company formed, established, or created	Centauri was founded in 2014 and incorporated in Delaware in 2016.
Ownership structure	Centauri Health Solutions, Inc. is a privately held, private equity financed company.
Total number of employees	Centauri has roughly 1,600 employees.
Services provided in other states	Centauri Health Solutions currently provides services to our affiliates in 21 Medicaid Markets including the State of Nebraska.
Physical location	16260 North 71st Street, Suite 325, Scottsdale, AZ, 85254

See Figure V.K.49-12. Organizational Chart — Centauri Health Solutions, Inc. on the page that follows

Figure V.K.49-12. Organizational Chart — Centauri Health Solutions, Inc.

Centauri Health Solutions, Inc. Organizational Chart



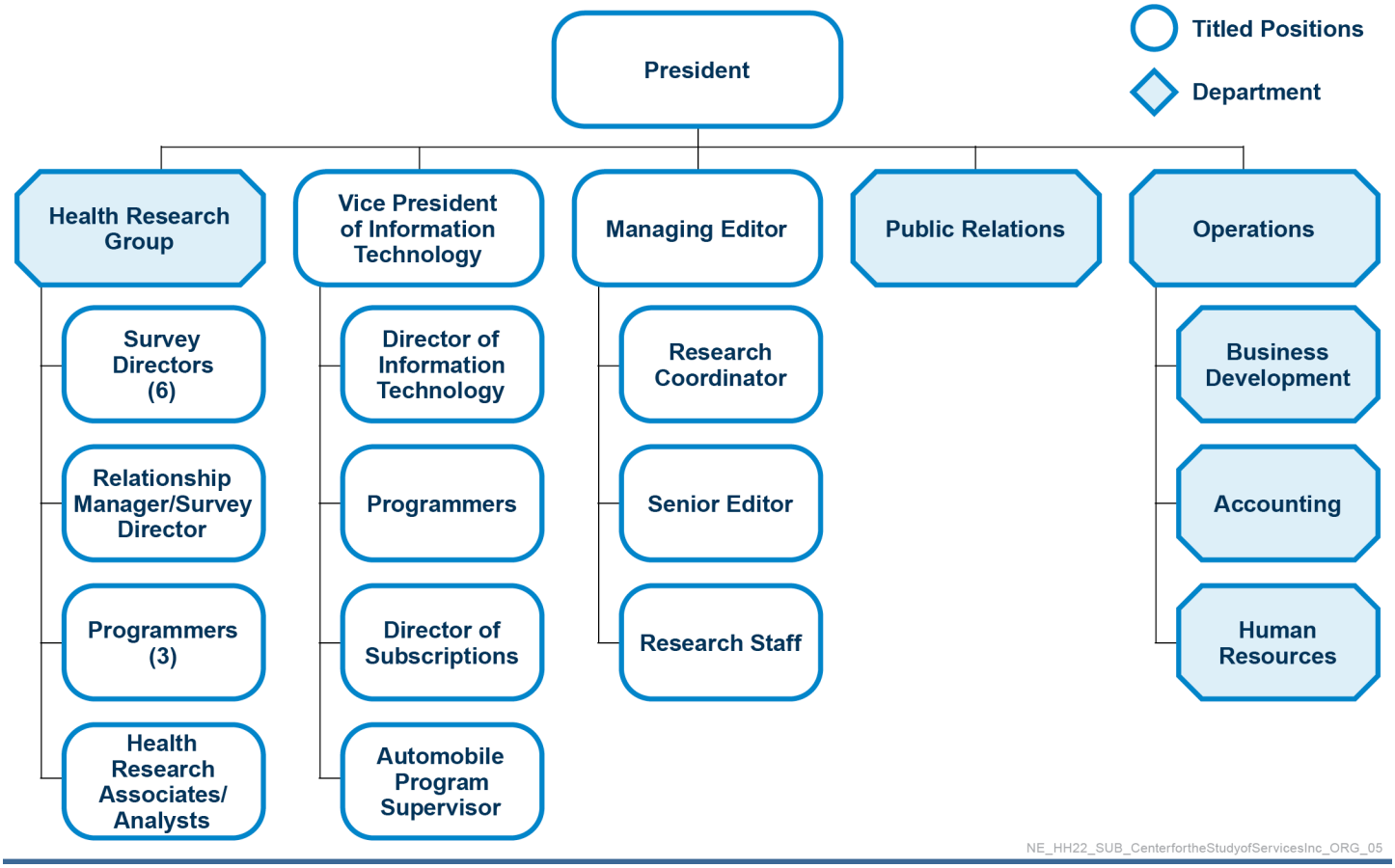
NE_HH22_SUB_CentauriHealth_ORG_03

Center for the Study of Services, Inc. (CSS)	
Description of role in project, Size, Resources and Corporate Background	Center for the Study of Services, Inc. (CSS) will conduct market research surveys that are required for accreditation and other regulatory purposes including CAHPS® member and provider satisfaction surveys. When conducting these surveys, CSS uses the NCQA-approved HEDIS CAHPS protocol for accreditation. CSS is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation to perform, interpret, and report on HEDIS CAHPS surveys (six survey certifications) ▪ CMS — certified to perform, interpret, and report on Medicare CAHPS and QHP CAHPS CSS conducts surveys of PCPs, specialty physicians, and practice managers for several national and regional health plans. Using a combination of online, mail, phone, and fax methodologies, they have experience surveying both commercial and Medicaid providers. In addition to surveys, CSS also publishes information for consumers about services (including health care) under the moniker Consumers Checkbook. For these publications both in print and online, Checkbook researchers call various service agencies throughout the year using a mystery shopper model to assess the availability and cost of their services. In 1994, CSS developed and implemented the first nationwide survey of health plan members for public reporting, surveying 150,000 members of 265 health plans participating in the Federal Employees Health Benefits program. In 1999, NCQA began certifying survey vendors to conduct the HEDIS/CAHPS survey and CSS was among the first vendors certified to conduct it. By 2006, CSS' CAHPS portfolio increased to include Medicare CAHPS surveys for all Medicare beneficiaries in traditional Medicare as well as Medicare Advantage.
Date company formed, established, or created	CSS was founded and incorporated in Washington, DC in April of 1994.
Ownership structure	Center for the Study of Services, Inc. is a 501c3 nonprofit organization.
Total number of employees	CSS has 67 employees.
Services provided in other states	CSS currently provides services to our affiliates in 24 Medicaid markets including the State of Nebraska.
Physical location	1625 K Street NW, Suite 800, Washington, DC, 20006

See Figure V.K.49-13. Organizational Chart — Center for the Study of Services, Inc. (CSS) on the page that follows

Figure V.K.49-13. Organizational Chart — Center for the Study of Services, Inc. (CSS).

Center for the Study of Services, Inc. Organizational Chart

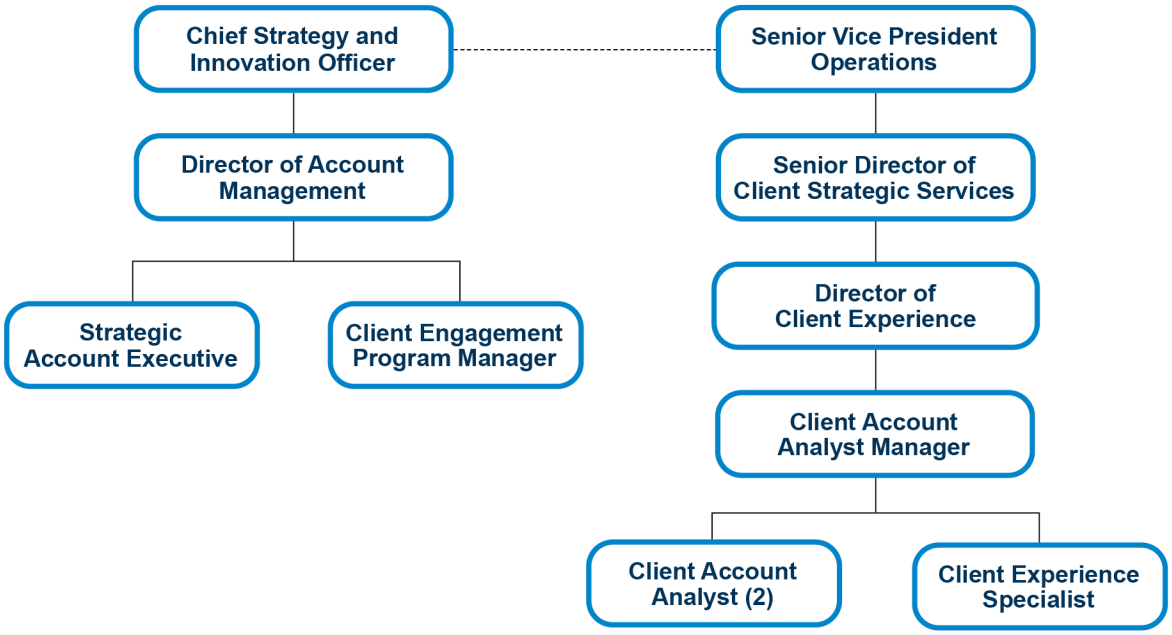


Clarity Software Solutions, Inc.	
Description of role in project, Size, Resources and Corporate Background	Clarity Software Solutions, Inc. (Clarity) supports the production and fulfillment of member ID cards for Healthy Blue. Clarity provides Healthy Blue with a customized platform allowing Healthy Blue to manage and validate that ID card production and fulfillment meets all regulatory and compliance requirements. Clarity is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Clarity supports ID card production for more than 60 million members across all lines of business in all 50 states and Puerto Rico. They currently partner with more than 100 multi-line health plan payers, dental plans, and pharmacy benefit managers, including three national health plan payers
Date company formed, established, or created	Clarity was founded and incorporated in the State of Connecticut in 2007.
Ownership structure	Clarity Software Solutions, Inc. is a privately held company.
Total number of employees	Clarity has 270 employees.
Services provided in other states	Clarity Software Solutions currently provides services to our affiliates in 23 Medicaid Markets, including the State of Nebraska.
Physical location	92 Wall Street, Madison, CT 06443

See Figure V.K.49-14. Organizational Chart — Clarity Software Solutions, Inc. on the page that follows

Figure V.K.49-14. Organizational Chart — Clarity Software Solutions, Inc.

Clarity Software Solutions, Inc. Organizational Chart



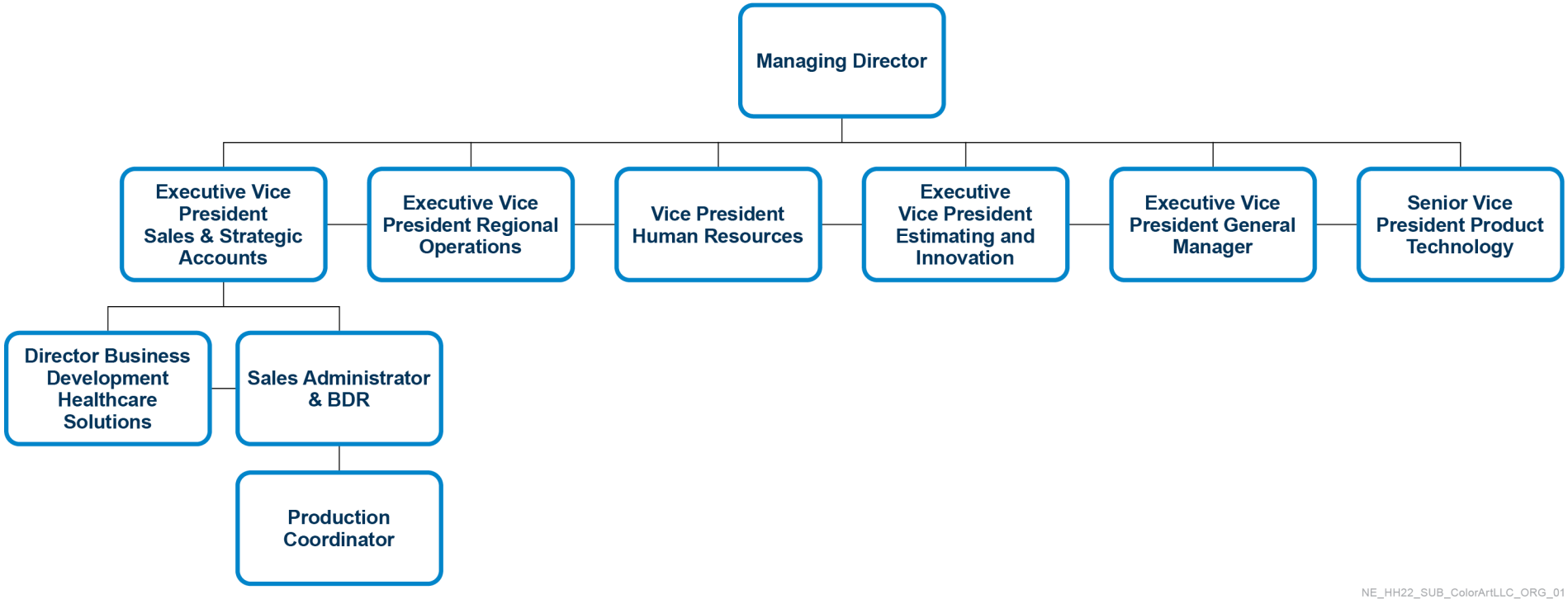
NE_HH22_SUB_ClaritySoftware_ORG_04

ColorArt, LLC	
Description of role in project, Size, Resources and Corporate Background	ColorArt, LLC (ColorArt) provides printing and fulfillment services to Healthy Blue. ColorArt prints, binds, and mails Pregnancy Resource Guides and Pre-Natal flyers to Healthy Blue members and will also be leveraged for designated ad-hoc printing and fulfillment jobs as needed. ColorArt is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ CMS — security certification (includes HIPAA compliance validation) ▪ ISO-27001:2013 — systems and data integrity certification ▪ Family Education and Rights Security Act (FERPA) certification — validation of data privacy and integrity for member communications ColorArt serves a wide variety of health care customers with requirements to comply with different regulatory needs such as HIPAA and NIST 800-53 Framework. ColorArt deploys and maintains security protocols based on ISO best practice guidelines for security, availability, processing integrity, confidentiality, and privacy. Their health care expertise extends to: ▪ Medicare and Medicaid ▪ Consumer Markets ▪ Pharmacy Benefit Managers ▪ Third-party Administrators ▪ 508-Compliant PDFs ▪ PII, PHI, HIPAA, CMS & ISO 27001 Compliant Workflow ▪ 20+ years in the managed health care industry ▪ CMS Compliance
Date company formed, established, or created	ColorArt was founded and incorporated in North Carolina in June of 2021.
Ownership structure	ColorArt, LLC is a privately held LLC owned by JAL, which was founded in 2008.
Total number of employees	ColorArt has 880 employees.
Services provided in other states	ColorArt currently provides services to our affiliates in 24 Medicaid Markets including the State of Nebraska.
Physical location	101 Workman Ct., Eureka, MO 63025

See Figure V.K.49-15. Organizational Chart — ColorArt, LLC on the page that follows

Figure V.K.49-15. Organizational Chart — ColorArt, LLC.

ColorArt, LLC Organizational Chart

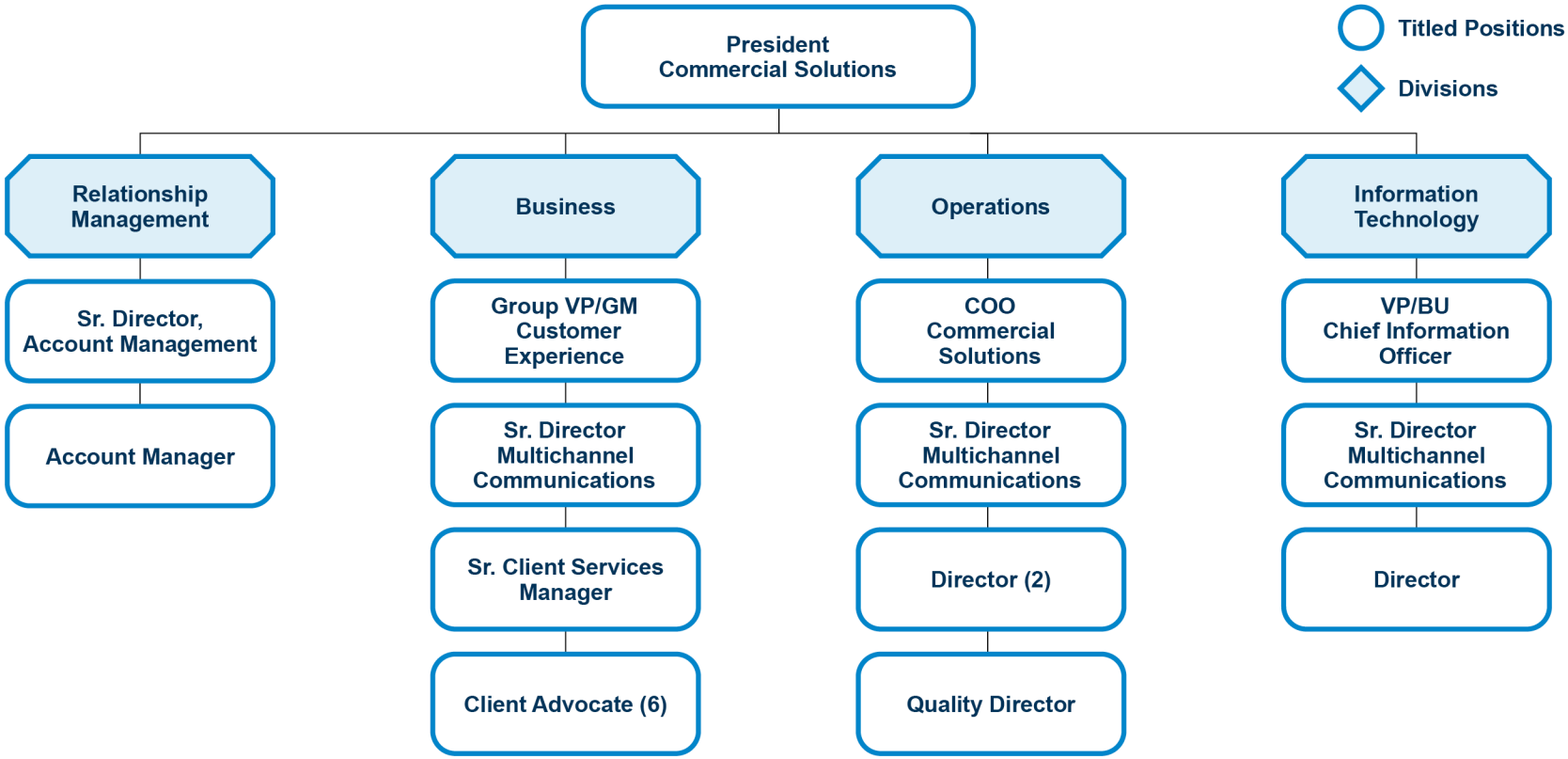


Conduent, Inc.	
Description of role in project, Size, Resources and Corporate Background	Conduent, Inc. (Conduent) provides print production, outbound printed communication fulfillment, and mailroom intake services to Healthy Blue. Conduent is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 1, Type 1 Standard certification — adequate process controls in place ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results ▪ ISO-27001:2013 — systems and data integrity certification Conduent has been providing print and front-end services to Elevance Health for more than 10 years and currently offers business solutions that touch more than 15 million Medicaid members across the nation.
Date company formed, established, or created	Conduent was founded 1982 and incorporated in the State of New York in 2002.
Ownership structure	Conduent, Inc. is a publicly traded company listed under the stock ticker symbol CNDT.
Total number of employees	Conduent has 63,000 employees.
Services provided in other states	Conduent currently provides services to our affiliates in 24 Medicaid Markets including the State of Nebraska.
Physical location	100 Campus Drive, Florham Park, NJ 07932

See Figure V.K.49-16. Organizational Chart — Conduent, Inc. on the page that follows

Figure V.K.49-16. Organizational Chart — Conduent, Inc.

Conduent, Inc. Organizational Chart

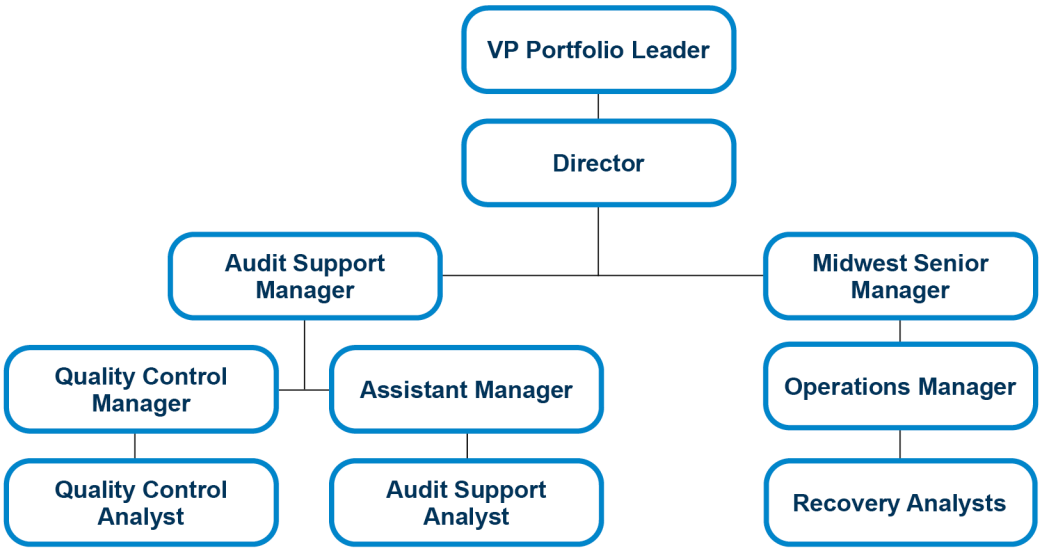


Conduent Credit Balance Solutions, LLC	
Description of role in project, Size, Resources and Corporate Background	Conduent Credit Balance Solutions, LLC (Conduent) will provide Healthy Blue support to analyze, validate, correct, and recover mispaid funds as the result of incomplete or incorrect benefit eligibility information, successful subrogation initiatives, and coordination of benefits processes. Conduent uses independent third-party assessors to conduct the following audits of its information systems and operations environments: ▪ SOC 1/ISAE3402 for processes related to financial statement reporting ▪ SOC 2/ISAE3000 for other processes, including privacy and General Data Protection Regulation (GDPR) processes and controls ▪ ISO-27001 where the need is certification of an information security management system Conduent's Credit Balance Solutions division was founded in 1989 and has been offering on-site credit balance auditing/processing for more than 33 years. The experience that Conduent offers extends from commercial insurance to state Medicaid plans. In the past 20 years, Conduent has recovered more than $288 million across in overpayments and has a 98% recovery rate on all identified overpayments.
Date company formed, established, or created	Conduent Credit Balance Solutions was founded in 1989 as a Delaware Corporation.
Ownership structure	Conduent Credit Balance Solutions, LLC is a wholly owned subsidiary of Conduent, Inc. Conduent, Inc. is a publicly traded company (NASDAQ: CNDT).
Total number of employees	Conduent Credit Balance Solutions has approximately 165 employees.
Services provided in other states	Conduent Credit Balance Solutions currently provides services to our affiliates in 18 Medicaid Markets. Conduent Credit Balance Solutions is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	100 Campus Drive, Suite 200, Florham Park, NJ 07932

See Figure V.K.49-17. Organizational Chart — Conduent Credit Balance Solutions, LLC on the page that follows

Figure V.K.49-17. Organizational Chart — Conduent Credit Balance Solutions, LLC.

Conduent Credit Balance Solutions, LLC Organizational Chart



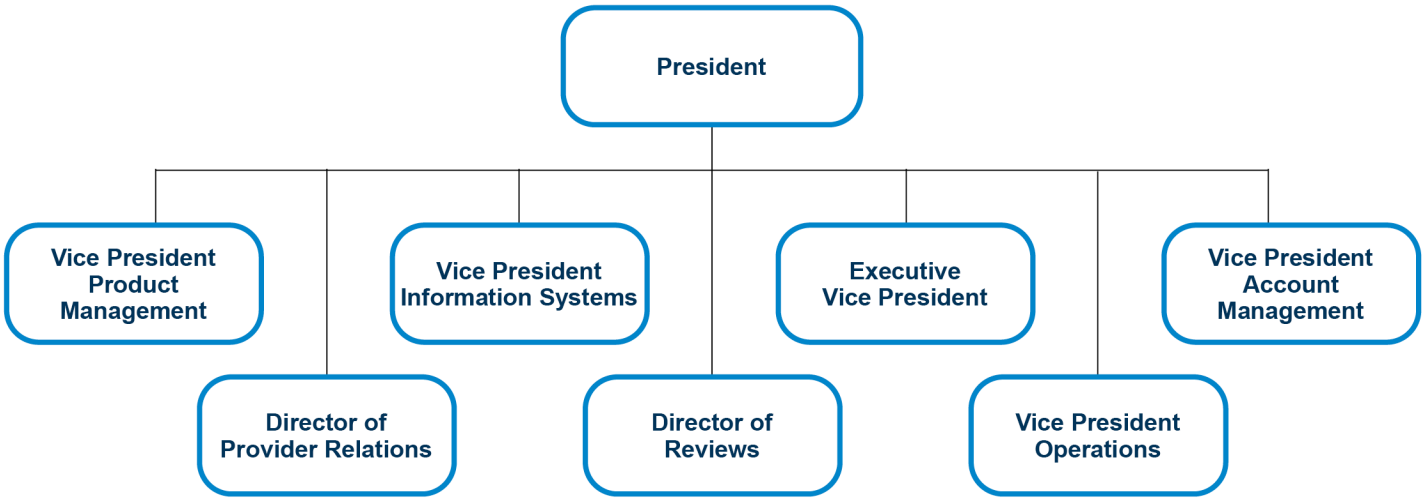
NE_HH22_SUB_ConduentCreditLLC_ORG_03

CERiS, Inc.	
Description of role in project, Size, Resources and Corporate Background	CERiS, Inc. (CERiS) will be performing itemized bill reviews for Healthy Blue. CERiS was introduced into Healthy Blue's claims processing workflow in April of 2021. From April of 2021 to April of 2022, CERiS has reviewed 7,300 Healthy Blue claims. CERiS is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met With more than 30 years of experience, CERiS is the prepay leader with savings on 97% of every claim processed, and prompt pay turnaround times exceeding contractual service level agreements setting them apart from their major competitors. Their Universal Chargemaster ensures reviews are consistent and accurate with minimal appeal. Claim analysis and reviews are conducted by licensed multispecialty facility nurses and are based on suggested corrections upon CMS non-separately billable guidelines and current professional practices. CERiS's fully certified and accredited staff complete reviews with medical directorship in compliance with Healthy Blue's policies. CERiS has experience performing prepay itemized bill reviews in 21 Medicaid states.
Date company formed, established, or created	CERiS was founded and incorporated in the State of Texas in 1989.
Ownership structure	CERiS, Inc. is the health division of CorVel Corporation.
Total number of employees	CERiS has 450 employees.
Services provided in other states	CERiS currently provides services to our affiliates in 21 Medicaid Markets, including the State of Nebraska.
Physical location	5128 Apache Plume Road, Suite 400, Fort Worth, TX 76109

See Figure V.K.49-18. Organizational Chart — CERiS, Inc. on the page that follows

Figure V.K.49-18. Organizational Chart — CERiS, Inc.

CERiS, Inc. Organizational Chart



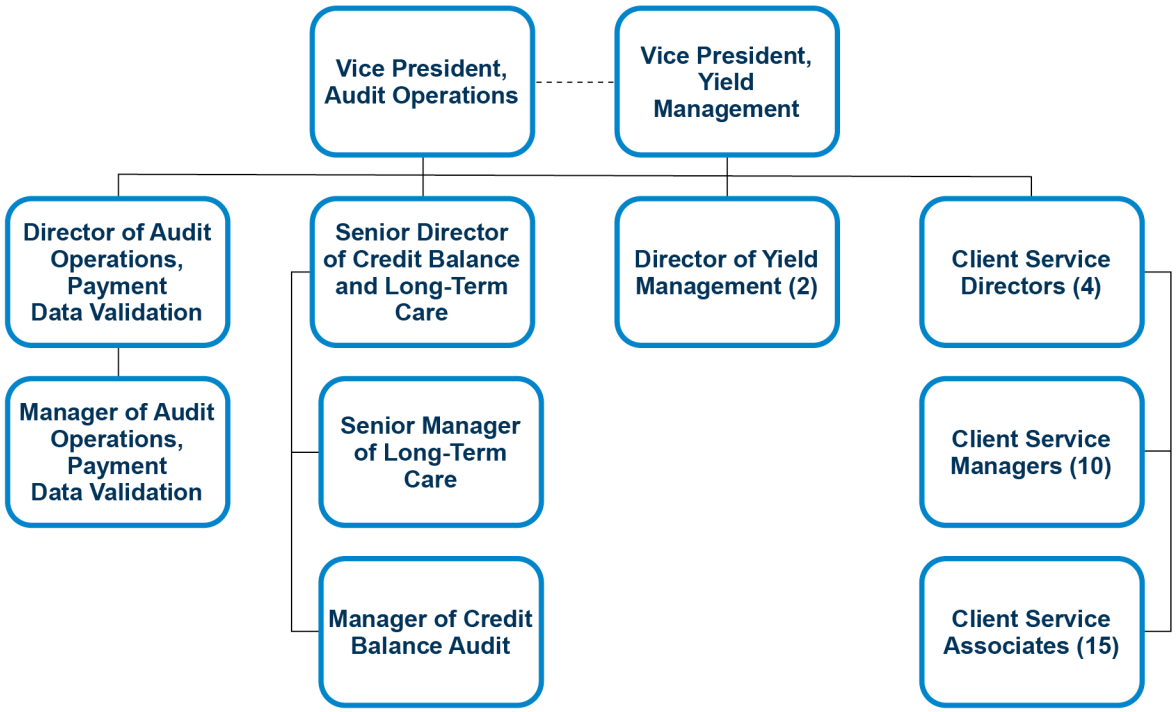
NE_HH22_SUB_CERiS_ORG_04

Cotiviti, Inc.	
Description of role in project, Size, Resources and Corporate Background	Cotiviti, Inc. (Cotiviti) provides post adjudication financial audit review for Healthy Blue to identify duplicate payments, coordination of benefits (COB) errors, and payments in excess of Healthy Blue's contractual requirements. Once an overpayment has been identified, Cotiviti submits their findings, along with all supporting documentation. Cotiviti has identified $100,000 in overpayments for Healthy Blue over the last 12 months. Cotiviti serves five of the six largest commercial payers and 14 Medicaid managed care plans across 39 states.
Date company formed, established, or created	Cotiviti was founded in 1979 and incorporated in Utah in 2004.
Ownership structure	Cotiviti, Inc. is a privately held company. The parent company of Cotiviti, Inc. is Verscend Holding Corp, which owns 100% of Cotiviti, Inc. The original company, Verisk Health, was formed in 2004 based on a series of acquisitions. The company was rebranded to Verscend Technologies in 2016 after it was sold by Verisk Analytics. We became Cotiviti, Inc., upon its acquisition of Cotiviti Holdings in 2018.
Total number of employees	Cotiviti has 7,000 employees.
Services provided in other states	Cotiviti currently provides services to our affiliates in 23 Medicaid Markets, including the State of Nebraska.
Physical location	10897 S. River Front Parkway, #200, South Jordan, UT 84095

See Figure V.K.49-19. Organizational Chart — Cotiviti, Inc. on the page that follows

Figure V.K.49-19. Organizational Chart — Cotiviti, Inc.

Cotiviti, Inc. Organizational Chart



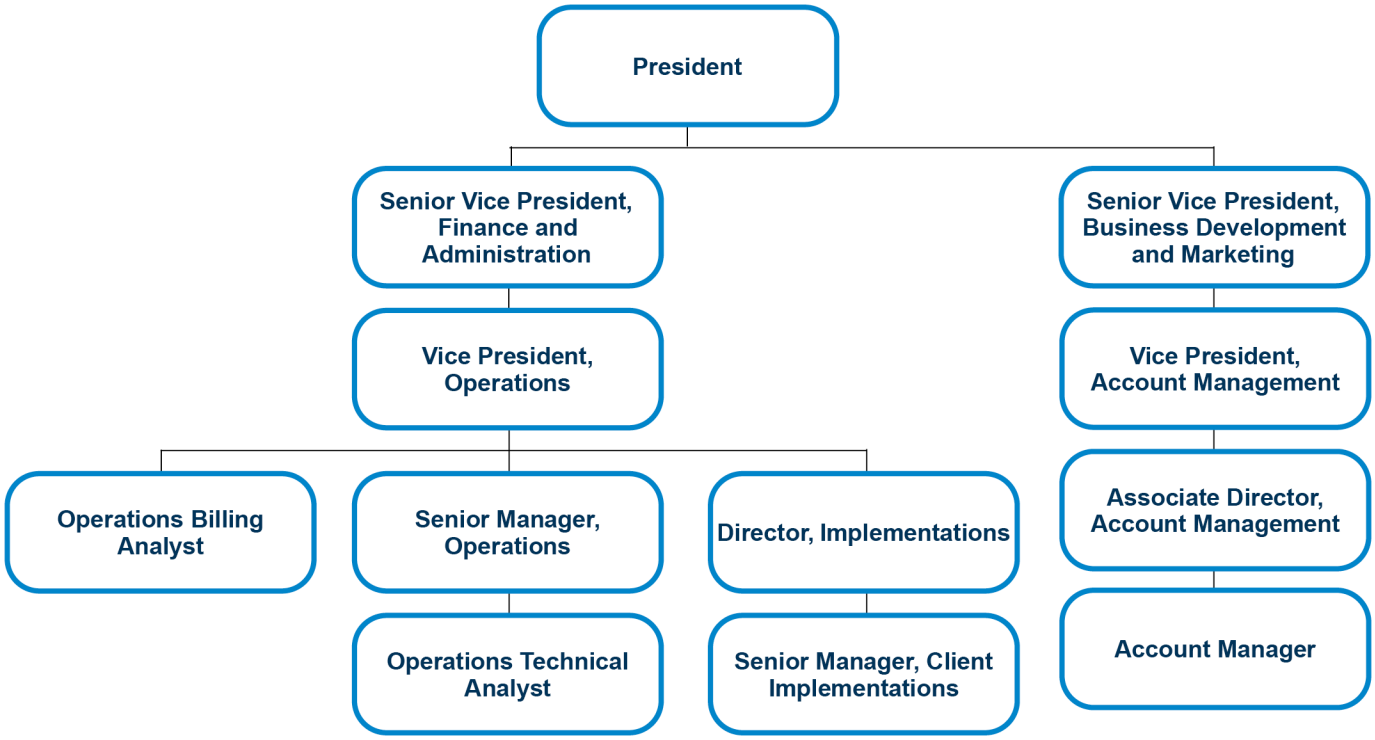
NE_HH22_SUB_CotivitiInc_ORG_02

Council for Affordable Quality Healthcare, Inc. (CAQH)	
Description of role in project, Size, Resources and Corporate Background	Council for Affordable Quality Healthcare, Inc. (CAQH) provides COB services by identifying overlaps in member coverage and reporting these to Healthy Blue on a weekly basis. CAQH determines the primacy of payment on the identified overlap by applying NAIC rules of member coverage coordination when possible. CAQH is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 3, Type 2 Standard certification — auditor's opinions, management assertion and system description CAQH provides Medicaid services and support to MCOs in all 50 states and has been in the role since 2014. Of the 217 million member records stored in CAQH's COB solution (COB Smart), 22% are in Medicaid managed care plans across all states with 0.62% being Nebraskans. Elevance Health is a founding member of CAQH and as such has been a recipient of the information and services CAQH has offered to the industry since 2000.
Date company formed, established, or created	CAQH was founded and incorporated in Washington, DC in 2000.
Ownership structure	Council for Affordable Quality Healthcare, Inc., is a privately held corporation.
Total number of employees	CAQH has 110 employees.
Services provided in other states	CAQH currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	2020 K Street, NW Suite 900, Washington, DC 20006

See Figure V.K.49-20. Organizational Chart — Council for Affordable Quality Healthcare, Inc. (CAQH) on the page that follows

Figure V.K.49-20. Organizational Chart — Council for Affordable Quality Healthcare, Inc. (CAQH).

Council for Affordable Quality Healthcare, Inc. (CAQH) Organizational Chart



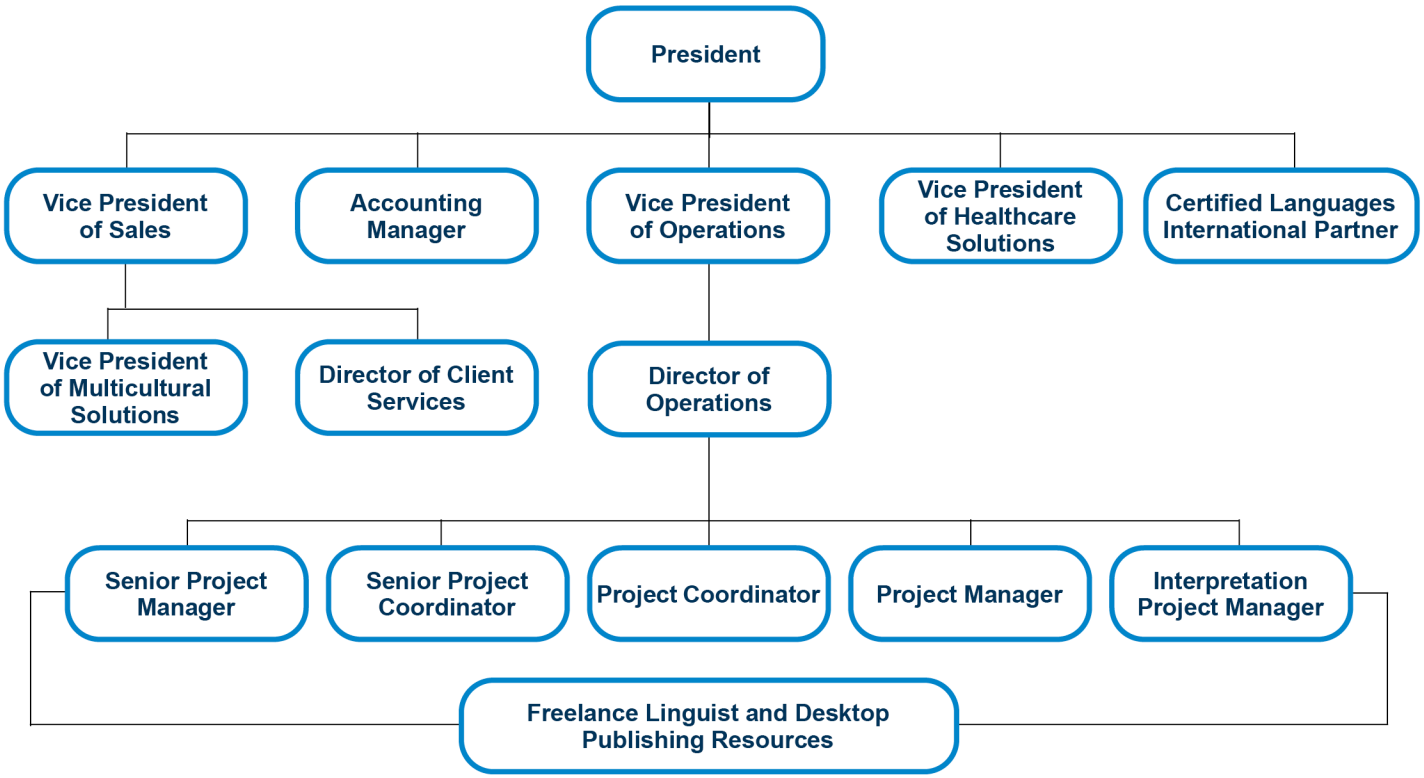
NE_HH22_SUB_CouncilforAffordableQualityHealthcare_ORG_05

CQ fluency, Inc.	
Description of role in project, Size, Resources and Corporate Background	CQ fluency, Inc. (CQ fluency) provides Healthy Blue document translation services and 508-compliance remediation support. CQ fluency is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ ISO certifications ○ 9901 — consistency in meeting quality and regulatory requirements ○ 17100:2015 — delivery of quality consistent and accurate translation services ▪ GDPR and HIPAA compliant CQ fluency provides language services to health plans including document translation into more than 250 languages. CQ fluency currently provides services to two of the three Medicaid health plans currently servicing Nebraskan's. In addition, CQ fluency currently supports more than 60 health plans; their managed care clients include many national health insurance organizations who provide Medicaid managed care services in all 50 US states. Through these insurers, CQ fluency provides services to millions of Medicaid lives. CQ fluency also holds a contract for the provision document translation services to CMS.
Date company formed, established, or created	CQ fluency was founded and incorporated in the State of New Jersey in 2000.
Ownership structure	CQ fluency, Inc. is a privately owned corporation that is a minority-owned (MBE) and woman-owned business enterprise (WBE).
Total number of employees	CQ fluency has 103 employees.
Services provided in other states	CQ fluency currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	2 University Plaza Drive, Suite 406, Hackensack, NJ 07601

See Figure V.K.49-21. Organizational Chart — CQ fluency, Inc. on the page that follows

Figure V.K.49-21. Organizational Chart — CQ fluency, Inc.

CQ fluency, Inc. Organizational Chart



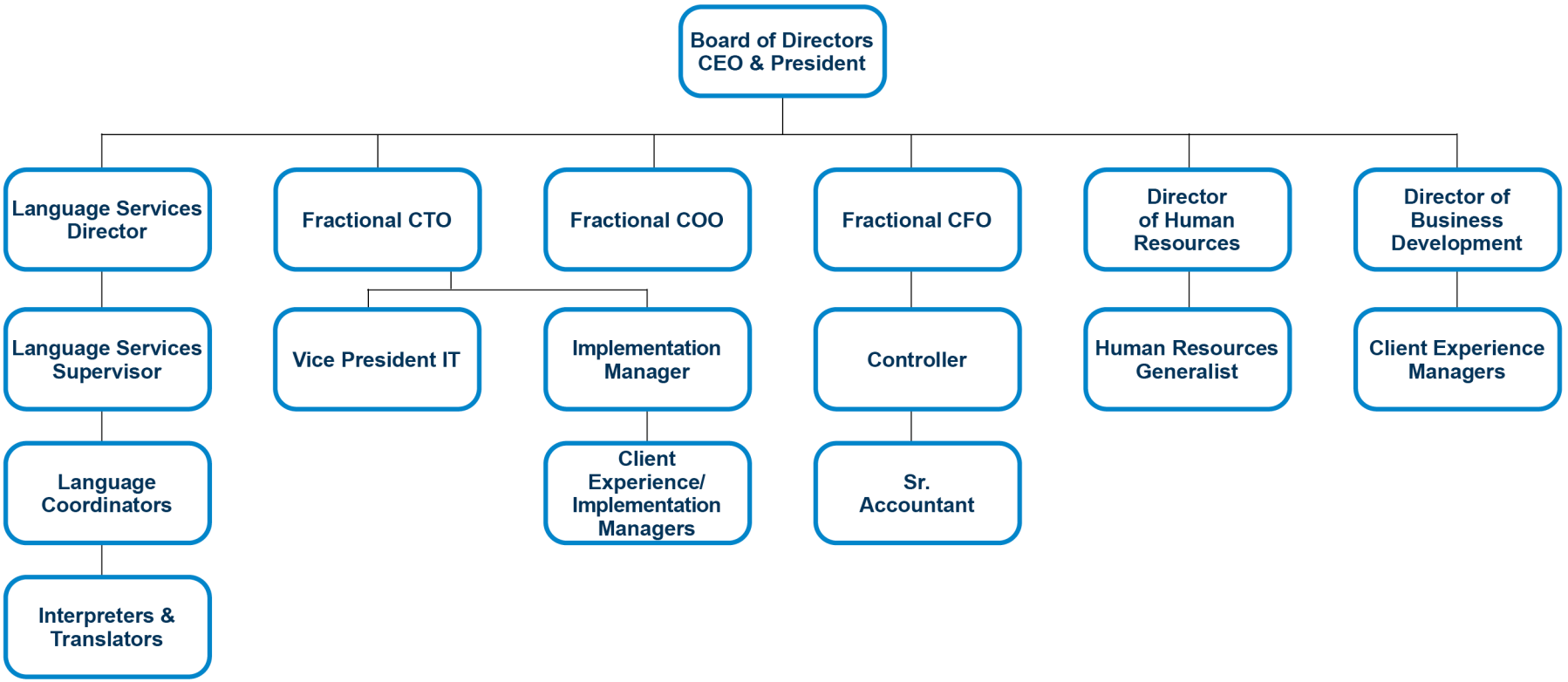
NE_HH22_SUB_CQFluency_ORG_04

CulturaLink, LLC	
Description of role in project, Size, Resources and Corporate Background	CulturaLink, LLC (CulturaLink) providers face-to-face language interpretation services to Healthy Blue members. CulturaLink has partnered with Elevance Health to deliver the like services to our members since 2010. CulturaLink has obtained the Certified Medical Interpreter designation. CulturaLink's sole focus is health care, with delivery of language services to more than 1,000 facilities in more than 200 languages. They partner with payors and health systems delivering services in 30 Medicaid markets across 21 states. In 2021 alone, CulturaLink successfully completed more than 16,820 language interpretations for Elevance Health members.
Date company formed, established, or created	CulturaLink was founded and incorporated in Delaware in 2006.
Ownership structure	CulturaLink, LLC is a limited liability corporation and an MBE and WBE.
Total number of employees	CulturaLink has 55 employees.
Services provided in other states	CulturaLink currently provides services to our affiliates in 22 Medicaid Markets, including the State of Nebraska.
Physical location	157 Technology Parkway Suite 600, Norcross, GA 30092

See Figure V.K.49-22. Organizational Chart — CulturaLink, LLC on the page that follows

Figure V.K.49-22. Organizational Chart — CulturaLink, LLC.

CulturaLink, LLC Organizational Chart



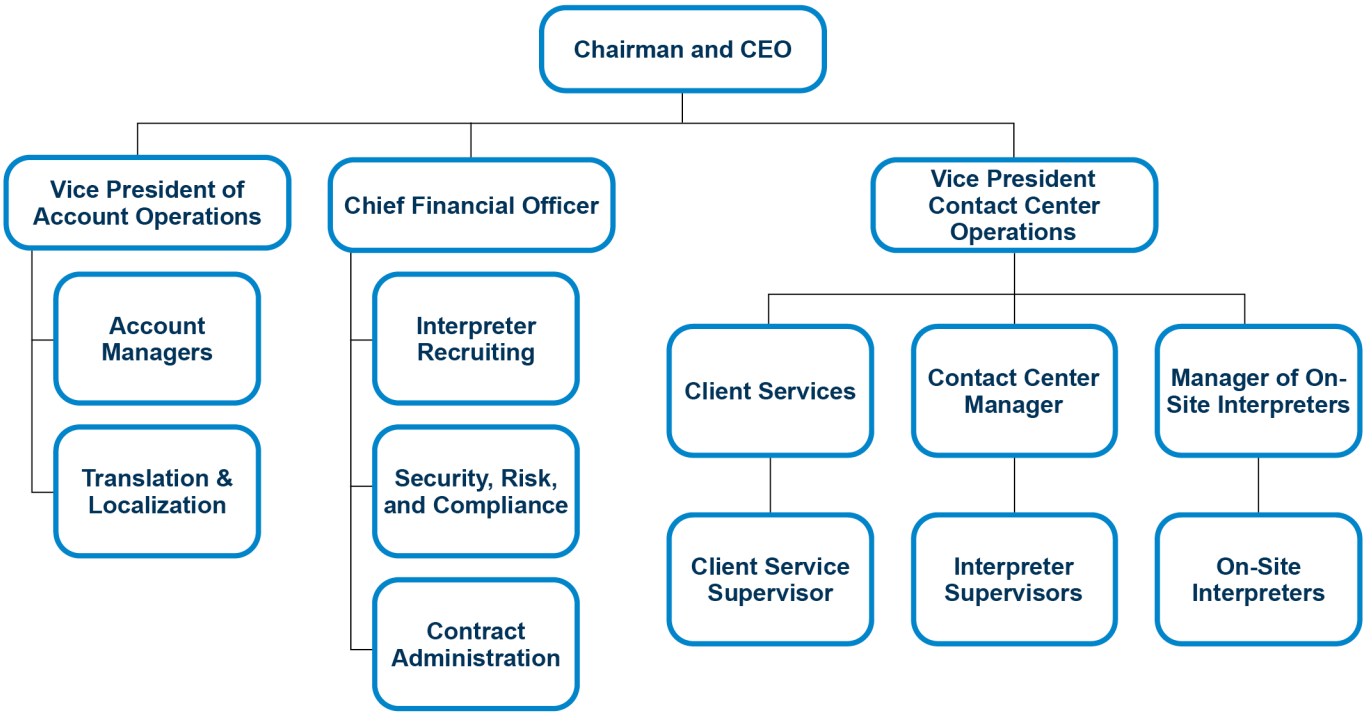
NE_HH22_SUB_CulturaLink_ORG_06

CyraCom International, Inc.	
Description of role in project, Size, Resources and Corporate Background	CyraCom International, Inc. (CyraCom) provision of service is limited to live conduit over-the-phone and on-site interpretation services. Healthy Blue uses CyraCom's services when an interpreter is needed to communicate between Healthy Blue and our members. CyraCom is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ ISO certifications ○ 17100:2015 — delivery of quality consistent and accurate translation services ○ 13485:2016 — medical device translation services ○ 27001:2013 — systems and data integrity CyraCom is a language solutions company and a leading provider of telephonic and on-site interpretation services across the US CyraCom has 26 years of experience in performing interpretation services and currently provides services for different government entities, such as the Department of Education, National Health Services, and the Department of Homeland Security. To provide services, CyraCom leverages a network of roughly 1,800 independent contractors that support interpretation services in more than 200 languages. In addition, CyraCom also follows the recommendations established under ISO 13611:2014 Guidelines for Community Interpreting.
Date company formed, established, or created	CyraCom was founded in 1995 and incorporated in Delaware in 1998.
Ownership structure	CyraCom International, Inc. is a privately owned corporation.
Total number of employees	[redacted]
Services provided in other states	CyraCom currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	2650 E. Elvira Road, Suite 132, Tucson, AZ 85756

See Figure V.K.49-23. Organizational Chart — CyraCom International, Inc. on the page that follows

Figure V.K.49-23. Organizational Chart — CyraCom International, Inc.

CyraCom International, Inc. Organizational Chart



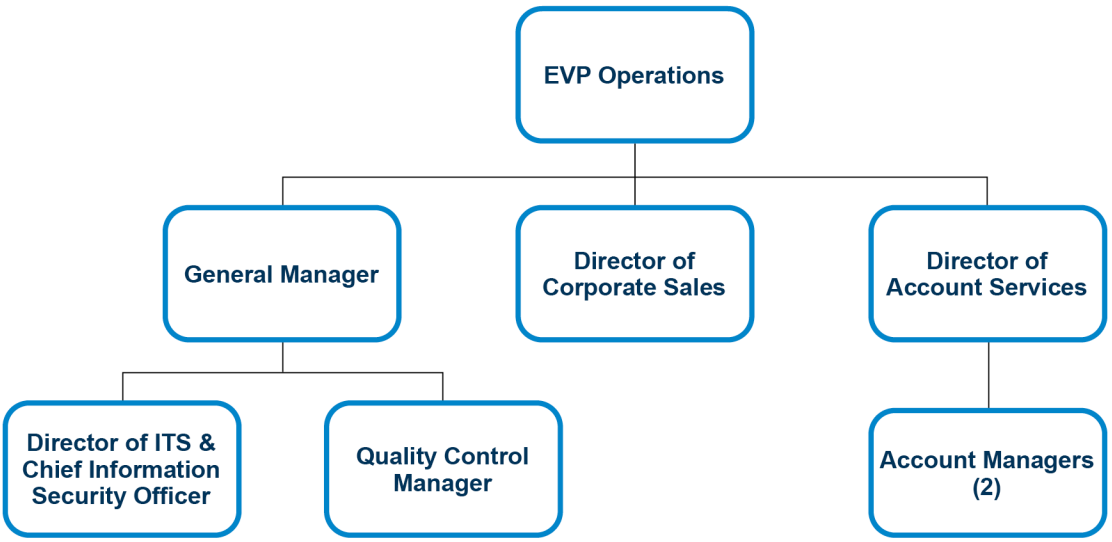
NE_HH22_SUB_CyraComIntl_ORG_04

Direct Technologies, Inc. (DTI)	
Description of role in project, Size, Resources and Corporate Background	Direct Technologies, Inc. (DTI) provides print and fulfillment services to Healthy Blue for member- and provider-facing communications. DTI also faxes provider communications as needed. DTI is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met DTI has provided services to health care organizations for more than 18 years and has partnered with Elevance Health for 13 of those years.
Date company formed, established, or created	DTI was founded and Incorporated in the State of Georgia in 2001.
Ownership structure	Direct Technologies, Inc. is a subsidiary of Doxim, Inc.
Total number of employees	DTI has 2,000 employees.
Services provided in other states	Direct Technologies currently provides services to our affiliates in 20 Medicaid markets, including the State of Nebraska.
Physical location	600 Satellite Blvd, Suwanee, GA 30024

See Figure V.K.49-24. Organizational Chart — Direct Technologies, Inc. (DTI) on the page that follows

Figure V.K.49-24. Organizational Chart — Direct Technologies, Inc. (DTI).

Direct Technologies, Inc. Organizational Chart



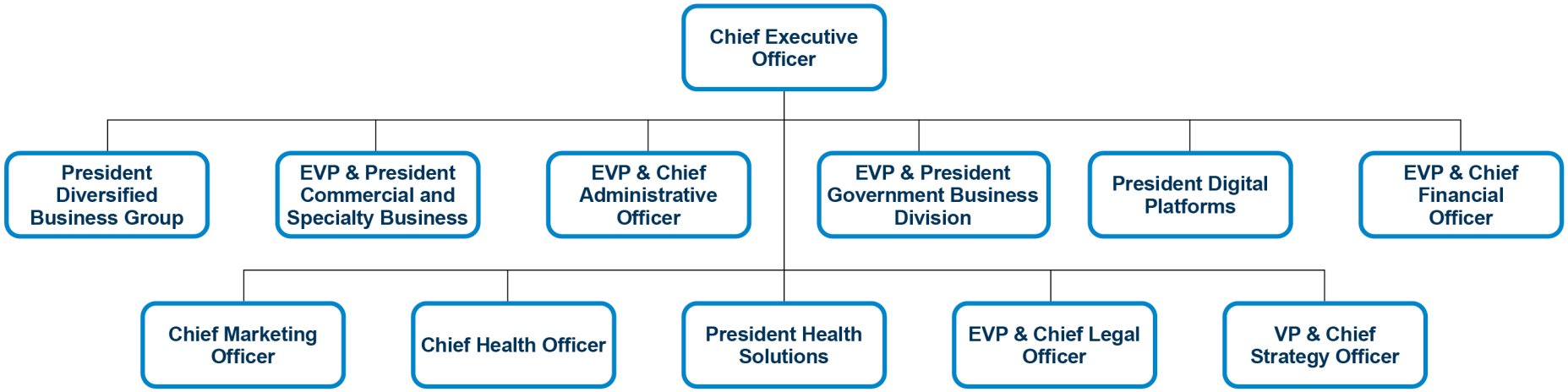
NE_HH22_SUB_DirectTech_ORG_03

Elevance Health, Inc. (Elevance Health)	
Description of role in project, Size, Resources and Corporate Background	Healthy Blue's parent company, Elevance Health, Inc. (previously known as Anthem, Inc.), provides administrative and support services including finance, claims administration, call center activities, information systems, legal, regulatory, treasury, and compliance. Through its health plan subsidiaries, Elevance Health, delivers health benefit solutions to more than 118 million members through a broad portfolio of integrated health care plans. Elevance Health covers more than 10.9 million Medicaid lives in 26 markets, including more than 113,000 lives in Nebraska. Elevance Health builds and maintains partnerships that deliver high-quality, cost-effective health care, underscored by consistently high levels of member and provider satisfaction. Through its affiliate health plans, Elevance Health has been coordinating and providing care for Medicaid populations across the nation for more than 30 years. Covered services include physical health, BH, dental, vision, pharmacy, NEMT, and long-term services and supports, with coverage varying by market. Elevance Health currently provides services to: ▪ 8.7 million TANF members in 24 markets ▪ 425,000 CHIP members in 19 market ▪ 117,000 children and adolescents in foster care and child welfare systems across 19 markets ▪ 302,000 members receiving LTSS across 11 markets ▪ 381,000 members with intellectual or developmental disabilities in 24 markets ▪ 630,000 members covered under an Aged, Blind, and Disabled (ABD) plan in 21 markets ▪ 10.4 million members across 23 markets receiving integrated BH services ▪ 1.9 million members under Medicaid expansion coverage in 16 markets
Date company formed, established, or created	The company was formed when WellPoint Health Networks Inc. and Anthem, Inc. merged in 2004. The complete and exact legal name of our parent company recently changed from Anthem, Inc. to Elevance Health, Inc. On March 10, 2022, Anthem, Inc. announced its intent to change its name to Elevance Health, Inc. The new name is the combination of "elevate" plus "advance" to underscore the company's commitment to innovation and in moving health care forward by elevating the importance of whole health and advancing beyond health care for consumers. The name change was officially approved in May 2022 and became effective on June 28, 2022.
Ownership structure	Elevance Health, Inc. is a publicly traded company listed on the New York Stock Exchange.
Total number of employees	Elevance Health has 95,597 employees.
Services provided in other states	Elevance Health provides services to its health plan subsidiaries across 26 Medicaid markets, including Nebraska.
Physical location	220 Virginia Avenue, Indianapolis, IN 46204

See Figure V.K.49-25. Organizational Chart — Elevance Health, Inc. (Elevance Health) on the page that follows

Figure V.K.49-25. Organizational Chart — Elevance Health, Inc. (Elevance Health).

Elevance Health, Inc. (Elevance Health) Organizational Chart



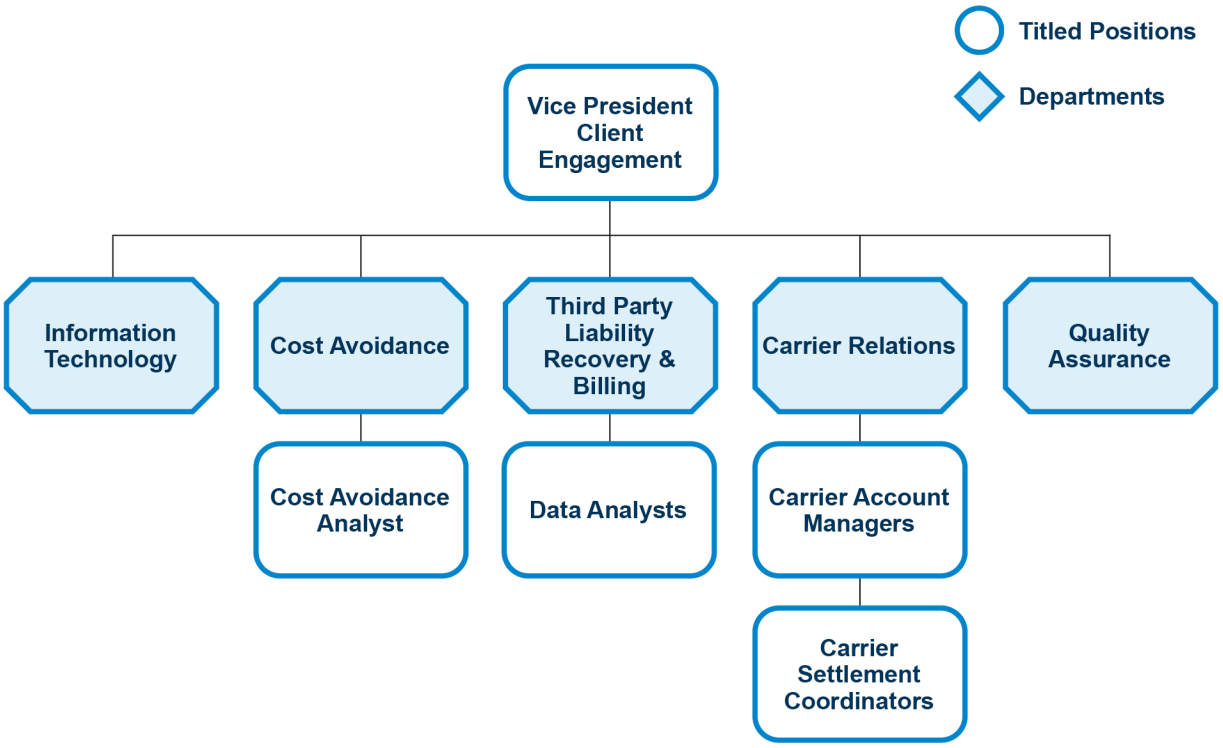
NE_HH22_SUB_AnthemInc_ORG_04

Health Management Systems, Inc.	
Description of role in project, Size, Resources and Corporate Background	Health Management Systems. Inc. (HMS) performs COB services for Healthy Blue. Specifically, HMS provides verified third-party liability (TPL) to assist in prepayment coordination of benefit and retrospective coordination of benefit (recoveries) where other coverage should have paid primary. HMS is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ ISO certification ○ 9901 — consistency in meeting quality and regulatory requirements HMS' extensive commercial and government experience includes providing cost containment services to more than 240 commercial plans and more than 40 state Medicaid programs, the US Department of Veterans Affairs facilities, CMS, and Department of Defense. HMS houses one of the most robust databases in the industry to facilitate payment accuracy and population health management. A recap of this dataset includes: ▪ More than 295 million unique lives' health coverage information ▪ More than 1.8 billion eligibility coverage segments ▪ More than seven petabytes of data ▪ More than 1,270 data trading partners (carriers, PBMs, employers, TPAs, etc.) ▪ More than three billion paid claim records received annually ▪ More than 23 billion consumer self-reported data points HMS has a proven, decade-long history of providing valuable cost containment services to Elevance Health.
Date company formed, established, or created	HMS was founded and incorporated in the State of New York in 1974.
Ownership structure	On April 1, 2021, Gainwell Acquisition Corp. (held by Veritas Capital, a private equity firm) acquired HMS Holdings Corp., including its subsidiary, Health Management Systems, Inc. In a related transaction, Cotiviti Inc. acquired certain HMS capabilities focused on population health management and, for the health care payor, Medicare, and federal markets, payment integrity. Gainwell Technologies LLC and Health Management Systems, Inc. are the operating entities of Gainwell Acquisition Corp. and will continue to operate as independent businesses. As such, Health Management Systems, Inc. is a sister company of Gainwell Technologies LLC.
Total number of employees	HMS has roughly 1,587 employees.
Services provided in other states	HMS currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	5615 High Point Drive, Irving, TX 75038

See Figure V.K.49-26. Organizational Chart — Health Management Systems, Inc. (HMS) on the page that follows

Figure V.K.49-26. Organizational Chart — Health Management Systems, Inc. (HMS).

Health Management Systems, Inc. (HMS) Organizational Chart



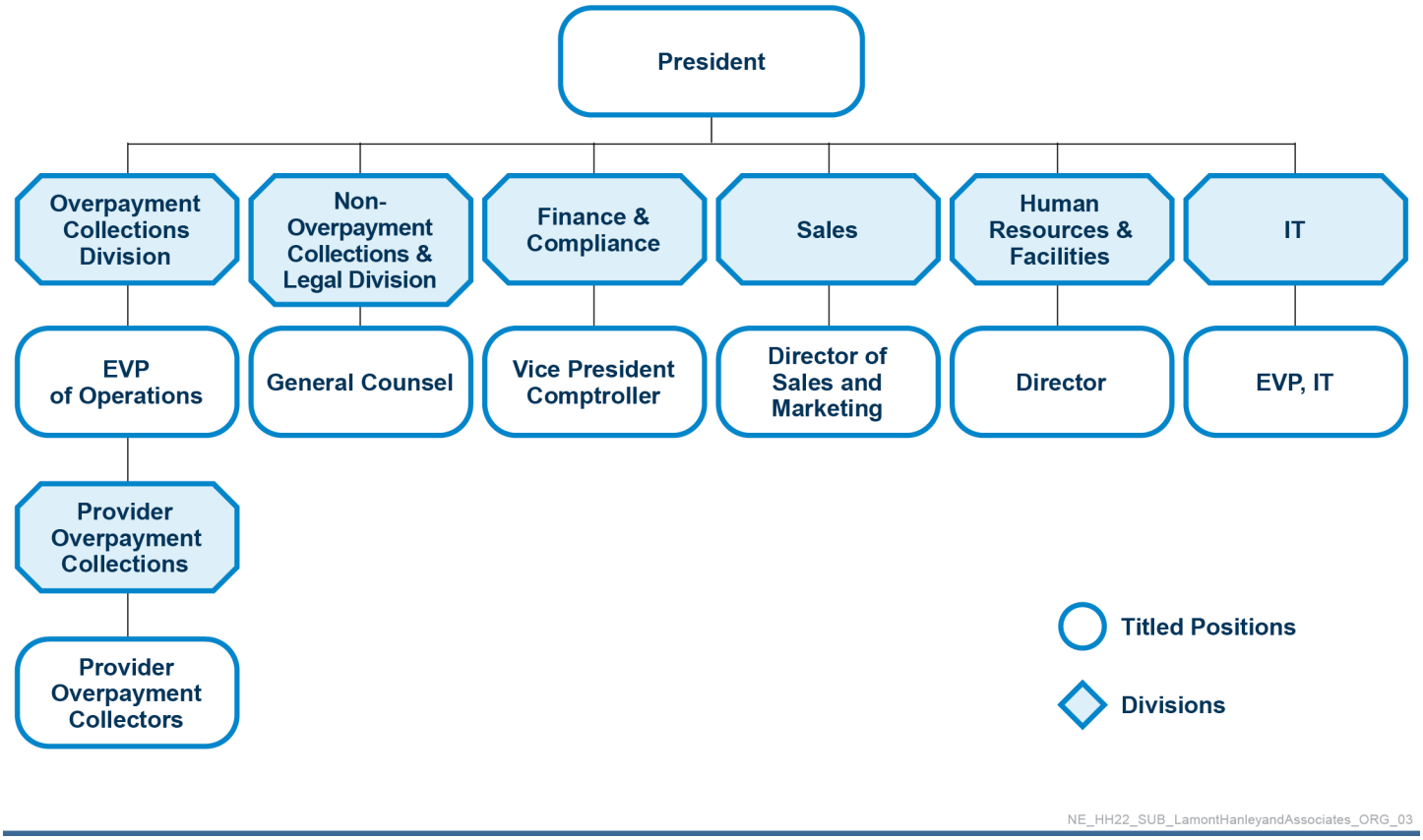
NE_HH22_SUB_HMSOrganizationAnthemClient_ORG_03

Lamont, Hanley & Associates, Inc. (LHA)	
Description of role in project, Size, Resources and Corporate Background	Lamont, Hanley & Associates, Inc. (LHA) provides overpayment recovery services to Healthy Blue. Their Provider Overpayment Recovery team and customer service staff actively supports Healthy Blue provider and member recovery activities. LHA is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results LHA provides account receivable management services for the insurance industry and has partnered with Elevance Health in support of over payment recovery efforts since 2014.
Date company formed, established, or created	LHA was founded and incorporated in the State of New Hampshire on August 16, 1991.
Ownership structure	Lamont, Hanley & Associates, Inc. is a privately held corporation.
Total number of employees	LHA has 54 employees.
Services provided in other states	LHA currently provides services to our affiliates in 19 Medicaid Markets. LHA is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	1138 Elm Street, Manchester, NH 03101

See Figure V.K.49-27. Organizational Chart — Lamont, Hanley & Associates, Inc. (LHA) on the page that follows

Figure V.K.49-27. Organizational Chart — Lamont, Hanley & Associates, Inc. (LHA).

Lamont, Hanley & Associates Inc. Organizational Chart

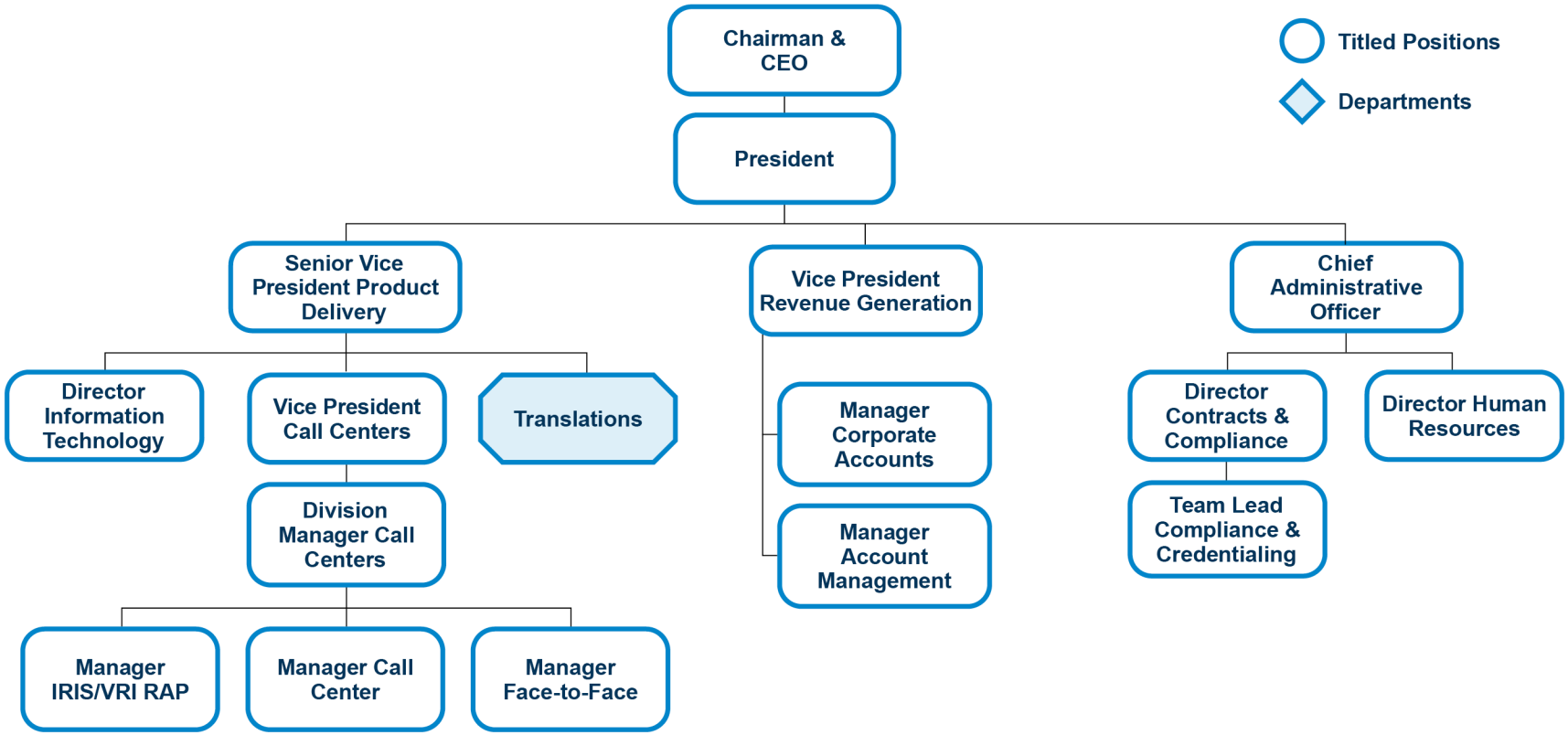


Language Services Associates, Inc.	
Description of role in project, Size, Resources and Corporate Background	Language Services Associates, Inc. (LSA) supports Healthy Blue by providing over-the-phone interpretation and in-person translation services. LSA has been providing interpretation services to health care and Medicaid clients for nearly 30 years. More than 65% of their clients are health care providers, which include large nationally recognized integrated delivery networks, community hospitals and health systems, Federally Qualified Health Centers, ancillary acute and non-acute facilities, clinics, physician groups, and practices.
Date company formed, established, or created	LSA was founded and incorporated in 1991 in the State of Pennsylvania.
Ownership structure	Language Services Associates, Inc. is a privately held corporation.
Total number of employees	LSA has 235 employees.
Services provided in other states	LSA currently provides services to our affiliates in 12 Medicaid Markets, including the State of Nebraska.
Physical location	455 Business Center Drive, Suite 100, Horsham, PA 19044

See Figure V.K.49-28. Organizational Chart — Language Services Associates, Inc. on the page that follows

Figure V.K.49-28. Organizational Chart — Language Services Associates, Inc.

Language Services Associates, Inc. Organizational Chart

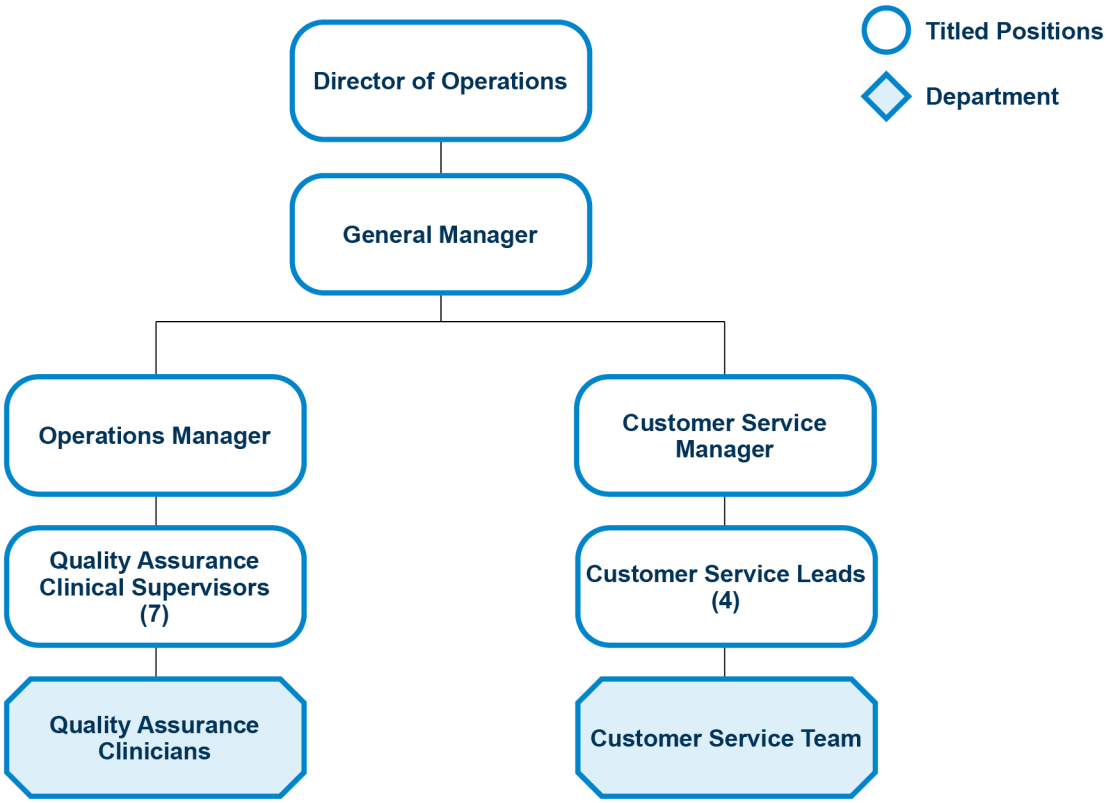


Lone Star Consulting Services, LLC (dba MES Peer Review Services)	
Description of role in project, Size, Resources and Corporate Background	Lone Star Consulting Services, LLC (dba MES Peer Review Services) provides Healthy Blue clinical peer review service support that assesses clinical peer decisions for appropriateness and/or efficacy of outcome. These review types include: ▪ Initial, prospective ▪ Concurrent ▪ Appeals (standard and expedited) ▪ Panel reviews ▪ Reconsiderations ▪ Peer-to-Peer MES completed 185 cases from February 2021 through April 2022 on behalf of Healthy Blue. MES is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — accreditation for utilization management and clinical review ▪ URAC — accreditation focused on quality outcomes and related oversight processes and procedures ▪ HITRUST certification — validating systems and HIPAA-level security standards met MES provides services to the Horizon Blue of New Jersey. Sunshine Health (Centene in Florida), UnitedHealthcare, AmeriHealth, Health Care Services Corporation, Aetna, Cigna, and Harvard Pilgrim amongst other MCOs. MES currently processes 20k to 25K reviews per month.
Date company formed, established, or created	MES Peer Review Services was incorporated in Delaware on February 1, 2004.
Ownership structure	MES Peer Review Services is organized as a limited liability company. The parent company of MES Peer Review Services is ExamWorks, LLC.
Total number of employees	MES Peer Review Services has 145 employees.
Services provided in other states	MES Peer Review Services currently provides services to our affiliates in three Medicaid markets, including Nebraska.
Physical location	100 Morse St. Norwood, MA 02062

See Figure V.K.49-29. Organizational Chart — Lone Star Consulting Services, LLC (dba MES Peer Review Services) on the page that follows

Figure V.K.49-29. Organizational Chart — Lone Star Consulting Services, LLC (dba MES Peer Review Services).

Lone Star Consulting Services, LLC (dba MES Peer Review Services) Organizational Chart



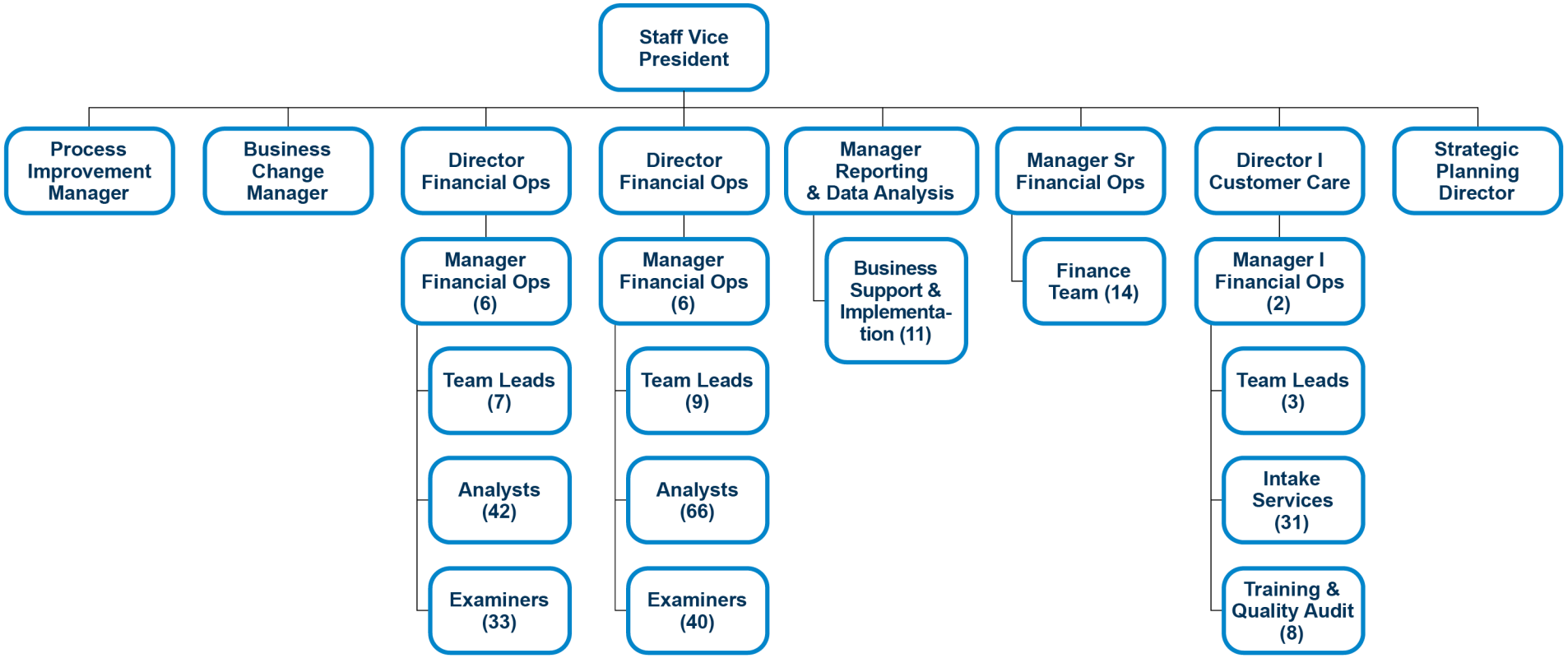
NE_HH22_SUB_MES_ORG_02

Meridian Resource Company, LLC	
Description of role in project, Size, Resources and Corporate Background	Meridian Resource Company, LLC (Meridian) provides Healthy Blue subrogation and TPL recovery support. Meridian has supported Healthy Blue since January of 2021 and is currently actively supporting 108 cases. Meridian has been an established subrogation subcontractor for more than 25 years with offices in Wisconsin, Kentucky, Indiana, and Ohio. They currently perform subrogation services in all 50 states managing subrogation and TPL recovery processes for more than 30 million lives. Meridian's flagship client is a Fortune 50 company that is one of the largest health care organizations in the world. They provided ~$340 million in total program savings in 2021 and are on pace to outperform that number by a significant margin in 2022. Meridian partners with multiple databases throughout the nation (including Verisk, state court dockets, federal dockets, CMS databases) to identify cases that would not normally be detected through a traditional questionnaire process.
Date company formed, established, or created	Meridian was founded and incorporated in the State of Wisconsin in 1993.
Ownership structure	Elevance Health, Inc. is the ultimate parent company of Meridian Resource Company, LLC,. Meridian Resource Company, LLC is a wholly owned subsidiary of Compcare Health Services Insurance Corporation, which is a wholly owned subsidiary of Blue Cross Blue Shield of Wisconsin, which is a wholly owned subsidiary of Crossroads Acquisition Corp., which is a wholly owned subsidiary of Anthem Holding Corp., which is a wholly owned subsidiary of Elevance Health, Inc., a publicly traded company.
Total number of employees	Meridian has 287 employees.
Services provided in other states	Meridian Resource Company currently provides services to our affiliates in 20 Medicaid Markets, including the State of Nebraska.
Physical location	N17W24340 Riverwood Drive, Waukesha, WI 53188

See Figure V.K.49-30. Organizational Chart — Meridian Resource Company, LLC on the page that follows

Figure V.K.49-30. Organizational Chart — Meridian Resource Company, LLC.

Meridian Resource Company, LLC Organizational Chart

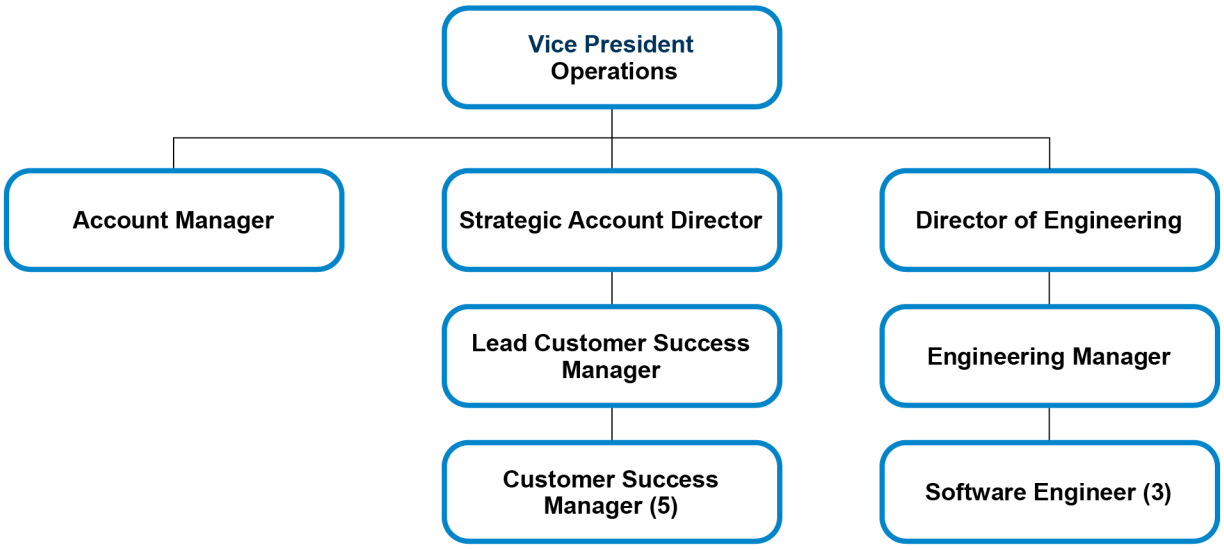


mPulse Mobile, Inc. (fka CrowdCircle)	
Description of role in project, Size, Resources and Corporate Background	mPulse Mobile, Inc. (fka CrowdCircle) (mPulse) supports Healthy Blue's member engagement efforts by performing digital outreach to close gaps in care and improve health care outcomes. Outreach is performed via SMS text message, interactive voice response, and email. Outreach campaigns are developed based on the needs of our members and support a range of projects, including redetermination efforts, health needs screenings, Health Risk Assessments, appointment reminders, and HEDIS gap closure. mPulse has touched 68,000 of our members since they began supporting Healthy Blue in June of 2021. mPulse is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met mPulse has provided outreach services to more than 30 million members in 34 states since their founding. They have served 109,000 Medicaid members to date by orchestrating health care communications that drive healthy actions closing gaps in care that leads to improved health care outcomes and improved HEDIS scores. On average, 5% of members that receive outreach respond positively and complete the call to action.
Date company formed, established, or created	mPulse was founded and incorporated in the State of California in August of 2014.
Ownership structure	mPulse Mobile, Inc. is a privately held corporation.
Total number of employees	mPulse has 227 employees.
Services provided in other states	mPulse Mobile currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	16530 Ventura Blvd. #500, Encino, CA 91436

See Figure V.K.49-31. Organizational Chart — mPulse Mobile, Inc. on the page that follows

Figure V.K.49-31. Organizational Chart — mPulse Mobile, Inc.

mPulse Mobile, Inc. Organizational Chart.



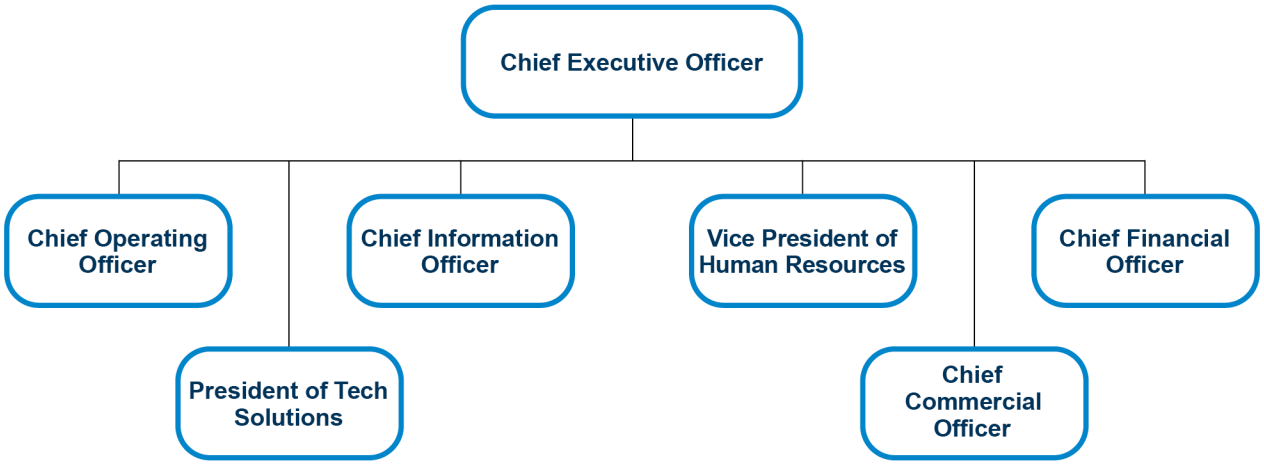
NE_HH22_SUB_MPulseMobile_ORG_05

OneTouchPoint Corp.	
Description of role in project, Size, Resources and Corporate Background	OneTouchPoint Corp. provides fulfills print and marketing collateral needs for Healthy Blue. In addition, OneTouchPoint Corp. will be supporting the launch of Elevance Health's Government Business Division Storefront in 2022. The storefront will provide a single solution that houses member materials in a secure and accessible database. OneTouchPoint Corp. is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results ▪ ISO certification ○ 9001:2015 — customer service and support In addition, OneTouchPoint Corp. is certified by the Forest Stewardship Council for responsible environmental and social practices OneTouchPoint Corp. capabilities span state-of-the-art printing, national and localized marketing execution, digital marketing, fulfillment, and related services delivered rapidly from facilities nationwide. They offer tech-enabled, managed print services for 40+ accounts across the health care and health insurance space. OneTouchPoint Corp. currently supports Medicaid programs across multiple states.
Date company formed, established, or created	OneTouchPoint Corp. was founded in 1982 and incorporated in the State of Delaware in 2007.
Ownership structure	OneTouchPoint Corp. is a privately held corporation owned by private equity firm ICV Partners.
Total number of employees	OneTouchPoint Corp. has 650 employees.
Services provided in other states	OneTouchPoint Corp. currently provides services to our affiliates in 23 Medicaid markets with Nebraska being added later in 2022.
Physical location	1225 Walnut Ridge Drive, Hartland, WI 53029

See Figure V.K.49-32. Organizational Chart — OneTouchPoint Corp. on the page that follows

Figure V.K.49-32. Organizational Chart — OneTouchPoint Corp.

OneTouchPoint Corp. Organizational Chart



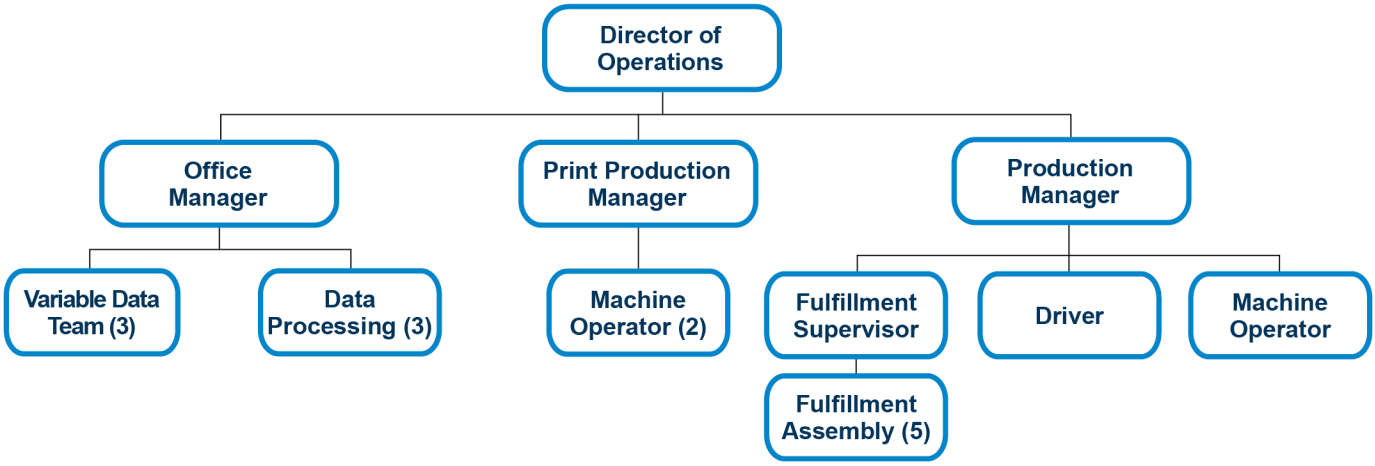
NE_HH22_SUB_OneTouchPoint_ORG_04

Preferred Direct Marketing Services, Inc.	
Description of role in project, Size, Resources and Corporate Background	Preferred Direct Marketing Services, Inc. (PDM) provides printing and direct mail services that support Healthy Blue's operations. Amongst other projects, PDM prints and mails Healthy Blue's member handbooks. PDM is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results ▪ PDM's controls are tested against the HITRUST In addition, PDM is pursuing G7 certification representing competence in systems replication of grayscale definition. PDM will be celebrating its 35th anniversary this year and has been a trusted partner of Elevance Health for more than 15 years, supporting multiple programs and initiatives.
Date company formed, established, or created	PDM was founded and incorporated in the Commonwealth of Virginia in 1987.
Ownership structure	Preferred Direct Marketing Services, Inc. is a partnership.
Total number of employees	PDM has 62 employees.
Services provided in other states	PDM currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	4590 Village Ave, Norfolk, VA 23502

See Figure V.K.49- 33. Organizational Chart — Preferred Direct Marketing Services, Inc. on the page that follows

Figure V.K.49-33. Organizational Chart — Preferred Direct Marketing Services, Inc.

Preferred Direct Marketing Services, Inc. Organizational Chart



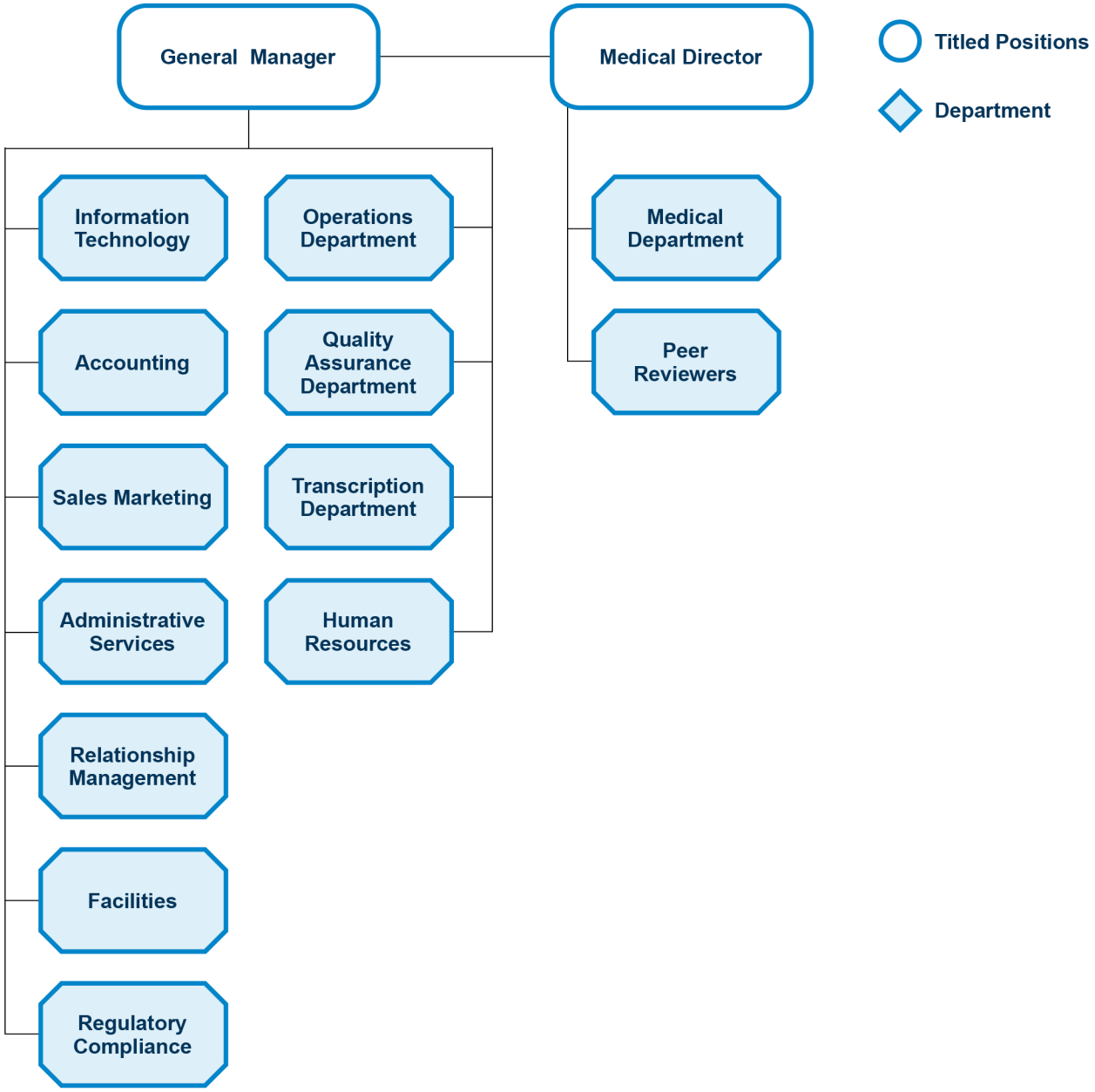
NE_HH22_SUB_PreferredDM_ORG_03

Prest & Associates, LLC	
Description of role in project, Size, Resources and Corporate Background	Prest & Associates, LLC (Prest) will support Healthy Blue by providing independent medical necessity reviews, including telephonic peer-to-peer reviews, in the fields of BH and addiction medicine. Prest is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ NCQA — full accreditation for exceptional clinical results and the delivery of quality services ▪ URAC — full accreditation on quality outcomes and related oversight processes and procedures ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results Prest has more than 30 years of experience as an independent review organization and reviews an average of 3,000 cases per month for clients across the US, which include national health carriers, state and local MCOs, and government agencies. Prest's review panel includes physicians with licenses in all US states enabling them to guarantee coverage wherever needed.
Date company formed, established, or created	Prest was founded in 1992.
Ownership structure	Prest & Associates, LLC is a wholly owned subsidiary of ExamWorks, LLC.
Total number of employees	Prest has 15 employees.
Services provided in other states	Prest currently provides services to our affiliates in 24 Medicaid Markets, including the State of Nebraska.
Physical location	401 Charmany Drive, Suite 305, Madison, WI 53719

See Figure V.K.49-34. Organizational Chart — Prest & Associates, LLC on the page that follows

Figure V.K.49-34. Organizational Chart — Prest & Associates, LLC.

Prest & Associates, LLC Organizational Chart

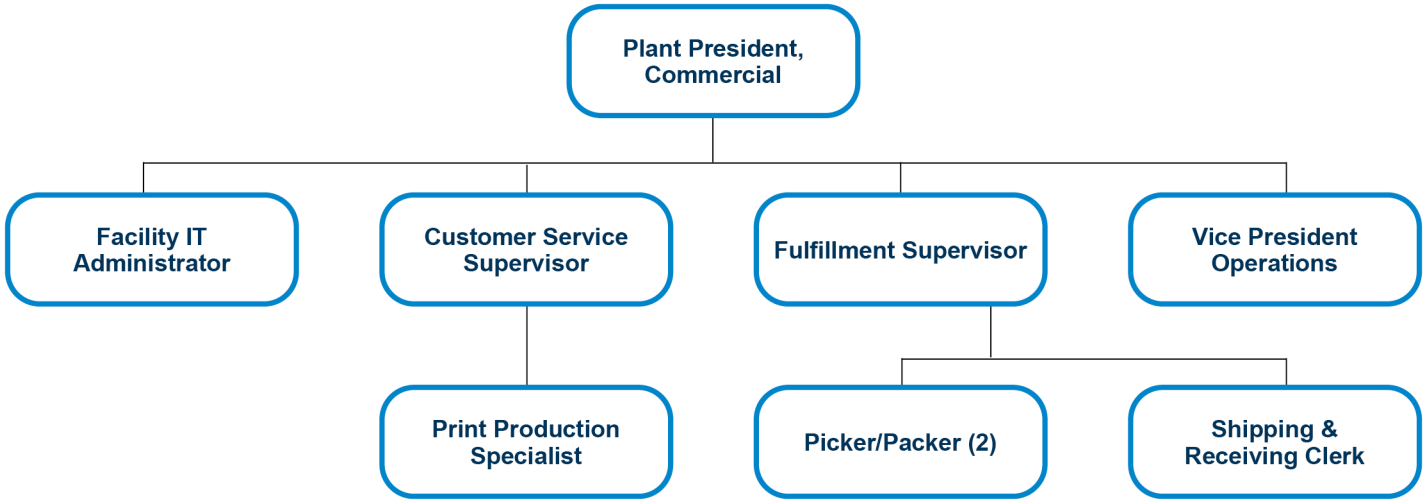


R.R. Donnelley & Sons Company	
Description of role in project, Size, Resources and Corporate Background	R.R. Donnelley & Sons Company (R.R. Donnelley) will support Healthy Blue's marketing team by providing print and direct mail services for member facing materials. R.R. Donnelley is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ HITRUST certification — validating systems and HIPAA-level security standards met ▪ SSAE SOC 2, Type 2 Standard certification — audit validation of process control results R.R. Donnelley helps organizations communicate more effectively by working to create, manage, produce, distribute, and process content. Products and service offerings include commercial print, packaging, labels, statement printing, supply chain management, forms, and business process outsourcing. R.R. Donnelley has been a trusted partner of Elevance Health for more than 20 years, supporting multiple programs and initiatives.
Date company formed, established, or created	R.R. Donnelley was founded in 1864 in the State of Illinois.
Ownership structure	Chatham, a private investment firm, acquired R.R. Donnelley & Sons Company in January 2022. R.R. Donnelley & Sons Company is a privately held company.
Total number of employees	R.R. Donnelley has 32,000 employees.
Services provided in other states	R.R. Donnelley currently provides services to our affiliates in nine Medicaid Markets. R.R. Donnelley is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	35 W. Wacker Drive, Chicago, IL 60601

See Figure V.K.49-35. Organizational Chart — R.R. Donnelley & Sons Company on the page that follows

Figure V.K.49-35. Organizational Chart — R.R. Donnelley & Sons Company.

R.R. Donnelley & Sons Company Organizational Chart



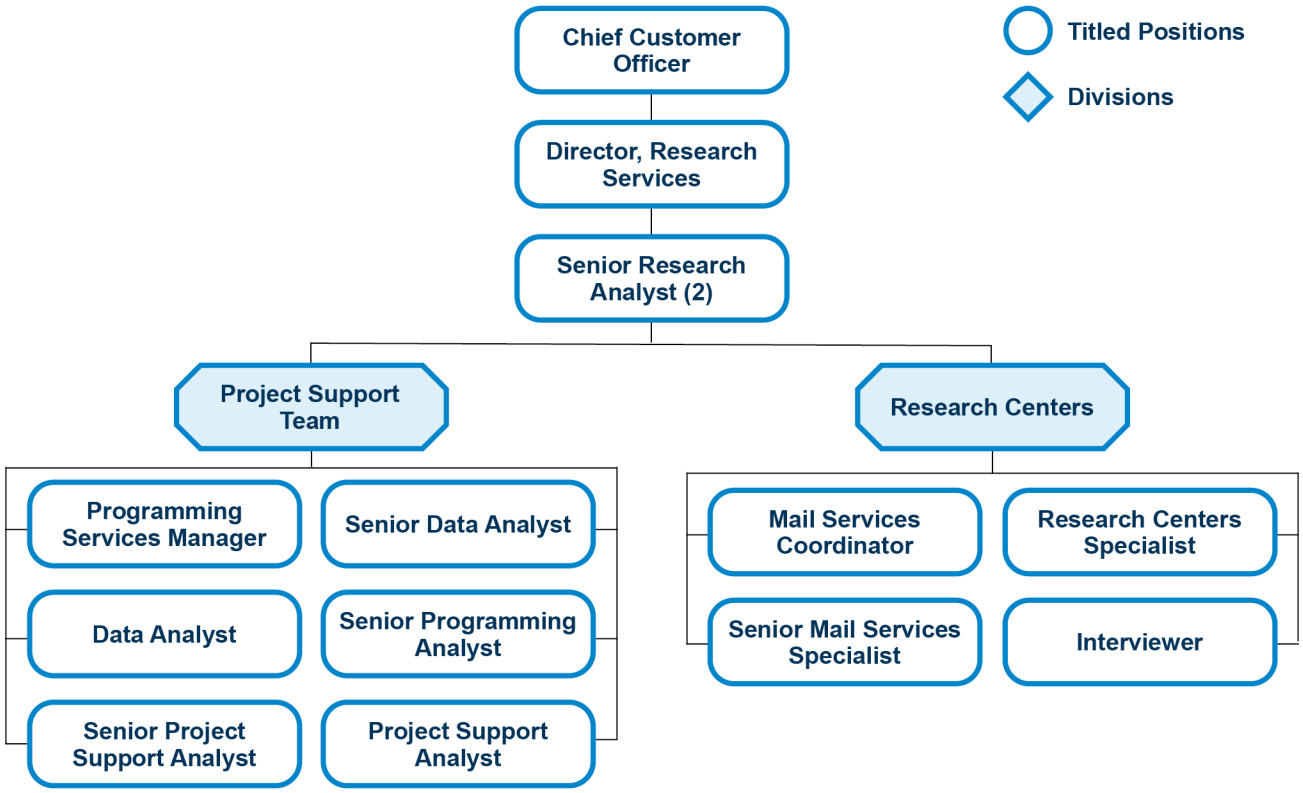
NE_HH22_SUB_RRDonnelley_ORG_03

The Dieringer Research Group, Inc.	
Description of role in project, Size, Resources and Corporate Background	The Dieringer Research Group, Inc. (DRG) will manage and execute Healthy Blue's member experience tracking program and care management satisfaction tracking program. Through these programs, DRG will interview Healthy Blue members to determine their satisfaction with the health plan and to understand their level of satisfaction with their Care Managers and Healthy Blue's case management program, respectively. DRG is committed to maintaining industry-recognized accreditations and/or certifications based on the services provided to Healthy Blue and possesses the following: ▪ ISO certification ○ 27001:2013 — systems and data integrity In addition, DRG is a certified woman-owned business nationally (Women's Business Enterprise National Council) and state-certified in and Missouri, Tennessee, and Wisconsin. DRG is a marketing research consulting firm that serves many industries, including health care and insurance, banking and finance, agencies, and utilities. DRG has been supporting the member experience tracking program for Elevance Health plans since 2005 and conducts approximately 60,000 interviews each year. DRG has been supporting the case management satisfaction tracking program for Elevance Health plans since 2014 and conducts approximately 8,000 interviews each year. DRG has been a trusted partner of Elevance Health's for nearly 20 years, supporting multiple programs and initiatives.
Date company formed, established, or created	DRG was founded in January of 1974 in the State of Wisconsin.
Ownership structure	The Dieringer Research Group, Inc. operates under an S-Corp operating structure.
Total number of employees	DRG has 84 employees.
Services provided in other states	The DRG currently provides services to our affiliates in 22 Medicaid Markets. DRG is a new subcontractor we are proposing to partner with in the State of Nebraska.
Physical location	200 Bishops Way, Brookfield, WI 53005

See Figure V.K.49-36. Organizational Chart — The Dieringer Research Group, Inc. on the page that follows

Figure V.K.49-36. Organizational Chart — The Dieringer Research Group, Inc.

The Dieringer Research Group, Inc. Organizational Chart



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No. 50

Monitoring and Evaluating Subcontractor Performance

As an incumbent health plan for the State of Nebraska, Healthy Blue has experience managing subcontractors, assuring they align with our mission and values. We view our subcontractors as an integral extension of our organization assisting in the delivery of meaningful services to our members. We understand the criticality of exercising subcontractor oversight, especially with those responsible for coordinating or directly delivering health care services to our members. Subcontractor oversight is a collaborative effort directly supported by the health plan, Nebraska-dedicated enterprise resources, and enterprise resources that provide programmatic support.

Healthy Blue's subcontractor oversight structure is accountable for the day-to-day operations and oversight of our subcontractors. Subcontractor oversight is a highly collaborative process leveraging skilled resources and best practices from across the enterprise to support local operations. Our program leverages enterprise tools and resources while focusing on local needs and initiatives, and this has made us a valuable partner to MLTC.

Our Subcontractor Oversight program provides the structure and processes integral to the central management of consistent and standardized oversight across all the different functional areas that contribute to the success of the program. Spearheaded by our Contract Compliance Officer, Christine Cole, Vendor Oversight Manager, and health plan leadership, our program is driven by three guiding principles:

- **Integrated Approach.** Subcontractor oversight is performed through a collaborative partnership between the health plan and enterprise. Our approach to subcontractor oversight accounts for the health plan's local presence and intimate knowledge of the priorities of our state partner, which is supplemented by enterprise resources and capabilities promoting a more dynamic oversight program.
- **Visibility to Drive Accountability.** The expanded scope of our committees (for example, the introduction of the Operational Excellence Committee) is designed to provide health plan leadership with increased visibility into subcontractor performance, enabling interventions, as necessary.
- **Constant Evolution.** Robust enhancements have been made to address the concerns of our State partner — we are introducing new subcontractors that bring value to our Heritage Health members while enhancing our operational performance oversight and monitoring.

We are presenting a high-level overview of our Subcontractor Oversight program, followed by a detailed review of specific strategies and program components that enable us to work with our subcontractors to deliver high quality, responsive service on an ongoing basis. Championed by our top-tier managed care leaders, our oversight processes deliver operational excellence that is collaborative, agile, and transparent. Our oversight teams, tools, and protocols enable us to continuously monitor subcontractor performance to assure they comply with applicable requirements and expectations and promptly identify and mitigate potential risks. We achieve this by:

- Answering questions, collaborating on problem solving, discussing opportunities for improvement, and escalating urgent performance concerns with our partners
- Assuring health plan leadership is actively engaged in subcontractor oversight through our responsive committee structure
- Obtaining and reviewing performance reporting with key metrics specific to functions delegated
- Facilitating regular meetings with the subcontractor (determined by functions the subcontractor is performing)
- Performing analysis on transactional data to identify potential anomalies that may trigger a focused review
- Issuing formal corrective action plans (CAPs) when instances of non-compliance are identified and performing follow-up to assure remediation
- Reviewing and analyzing complaints and grievances to identify trends
- Reporting monitoring activities to the Contract Compliance Officer
- Formalized performance audits using tools specific to the function delegated and mapped to contractual requirements and accreditation standards
- Identifying opportunities to leverage subcontractor assets to achieve health plan business goals
- Fostering a strong relationship with the subcontractor enables us tofacilitate invoice validation, timely payment, contract compliance, and opportunities for innovation

MLTC has every right to trust and rely upon their plan partners to manage fully accountable and compliant programs. For Healthy Blue, this means understanding that we are responsible for the work and service delivery of each one of our subcontractors. Healthy Blue acknowledges and will adhere to SOW K.1–3, to include 42 CFR 438.230. In addition, we will implement and adhere to the requests from MLTC, as noted previously in V.K.50.

Ensure Receipt of All Required Data Including Encounter Data

We ensure receipt of all required data including encounter data through secure data file transfers, such as secure file transfer protocols (SFTP). We oversee and validate subcontractor encounter data using an automated process that minimizes manual checks for completion. Our encounter data process includes quality assurance and an audit to verify completeness and accuracy of the data received. We validate and deliver accurate encounter data in compliance with all MLTC requirements. Each encounters process includes rigorous validation of data accuracy from claim adjudication through encounter file creation.

Front-end Claim Validation. Starting with claims processing, we subject submitted claims to extensive front-end edits during processing, denying those submitted without the data required by MLTC to support accurate encounter submissions. These automated validation edits verify that claims are relevant, complete, and contextually appropriate.

Encounter Quality Checks. To prevent encounter data submission issues, we maintain several checkpoints including:

- Logging details of each submission and capturing source claim information such as claim number, type (original, adjustment, void), file name, path, and creation date.
- Checking for and removing duplicate records.
- Reconciling queued encounter data to claims processed for eligible services during the matching time period (including paid, denied, and voided claims).

Verify HIPAA Compliance. We apply business rules based on MLTC submission requirements. Validation edits confirm that National Provider Identifiers and atypical providers follow encounter rules and format dates and occurrence spans correctly. Records that fail edits pend for review, investigation, and remediation. We promptly coordinate corrections and include the corrected encounter in a subsequent submission. Prior to submission, we perform quality checks on all encounter files to assure compliance with MLTC standards.

Continuous Monitoring. Using key performance metrics and dashboards enables us to continuously monitor and assess subcontractor encounter performance. Reviewing the summary statistics on encounters processed, submitted, internally pended, and rejected for all encounter types, help us evaluate the overall health of our encounter submissions. Additional details support the repair, remediation, and resubmission of rejected and internally pended encounters. If we identify gaps or errors, we use a systematic approach to investigate and resolve them. Depending on the nature of the issue, resolution may include business process improvements, claims processing procedure or configuration changes, provider data collection enhancements, and/or staffing changes.

[redacted]

Ensure Utilization of Health Care Services at an Appropriate Level

Employing a multipronged approach, we help to ensure our subcontractors deliver the appropriate utilization of health care services through regular performance reporting and our responsive committee oversight structure. Our subcontractors employ our nationally recognized clinical practice guidelines in making health care decisions. We leverage advanced technology and practices to optimize patient care from prior authorization checkpoints to fraud, waste, and abuse training. Further, in collaboration with our Quality Management department, we monitor over- and under-utilization of services while ensuring adherence to regulatory compliance. We adapt the scope and frequency of our oversight activities to reflect the nature of any delegated activities and the nuances of services provided, using our contractual obligations to MLTC as the foundation of our program.

Meeting All SOW Standards

We will assure the delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP's SOW. The subcontractors we select are an integral extension of our organization assisting in the delivery of meaningful services to members and are held to the same standards we are held to. Our subcontractor agreements include meaningful service level agreements that align with MLTC requirements for each function we delegate. We will leverage a multipronged approach to assure our subcontractors are delivering services in compliance with all RFP required standards. To ensure subcontractors meet all SOW standards, we deploy comprehensive oversight processes from initial vetting through the ongoing performance oversight and monitoring outlined on the following pages. Our approach includes pre-delegation and annual auditing, a responsive committee structure that assures health plan leadership is actively involved in oversight, subcontractor agreements that include performance guarantees and incentives for performance significantly exceeding standards, operational performance oversight and management conducted through our Nebraska Subcontractor Oversight program, including CAPs issued when performance is not meeting expectations. We retain sole responsibility for assuring our subcontractors fulfill all contractual performance obligations.

Ensure Adherence to Grievance Policies and Procedures

While Healthy Blue does not delegate grievances to any subcontractor, all subcontractors must adhere to our grievance policies and procedures. Our approach to ensuring adherence begins with communication. Informing our partners of our oversight policies and procedures is the first step. We also provide comprehensive education on policy and procedure content to verify full understanding of expectations. Additionally, we maintain regular communications with our subcontractors regarding policy and procedure revisions. Subcontractors are informed when a change is made to a policy and procedure tied to grievances so they can review changes, assess change impacts, and institute necessary adjustments to their operations. In addition to keeping all lines of communication open, we track and trend grievance data to address common issues and identify opportunities for continuous improvement. We review grievance data to identify volume changes, timeliness, trends, and key metrics such as the date the grievance was received, incoming urgency, date of the acknowledgement letter, reason for the grievance, date of resolution, and outcome. We use this data and request additional documentation, when necessary, to better understand trends so we can address the root cause of any identified issues. Our newly created, local Nebraska-based Vendor Oversight Manager (VOM) will meet with the subcontractor to discuss monitoring results, such as trends, remediation efforts, policy and procedure revisions, training opportunities, and recommended operational improvements.

Ensure Appropriate Reimbursement

We ensure our subcontractor agreements do not contain terms for reimbursement at rates less than the published Medicaid fee-for-service (FFS) rate without prior MLTC approval. We accomplish this by assuring our subcontractors are educated about this requirement and know what the Medicaid FFS rates are. Additionally, we will introduce a subcontractor claims data report enabling us to verify whether our subcontractors are reimbursing providers at a rate that is less than the published Medicaid FFS rate. If we find a subcontractor is not appropriately reimbursing providers, we will take corrective action to remediate the deficiency. [redacted]

In the pages that follow, we have described our comprehensive subcontractor oversight program, which delves further into the methods through which we:

- Ensure receipt of all required data including encounter data.
- Ensure that utilization of health care services is at an appropriate level.
- Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.
- Ensure adherence to required grievance policies and procedures.
- Ensure subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC.

Evaluation and Selection of Subcontractors

Integrated Subcontracting

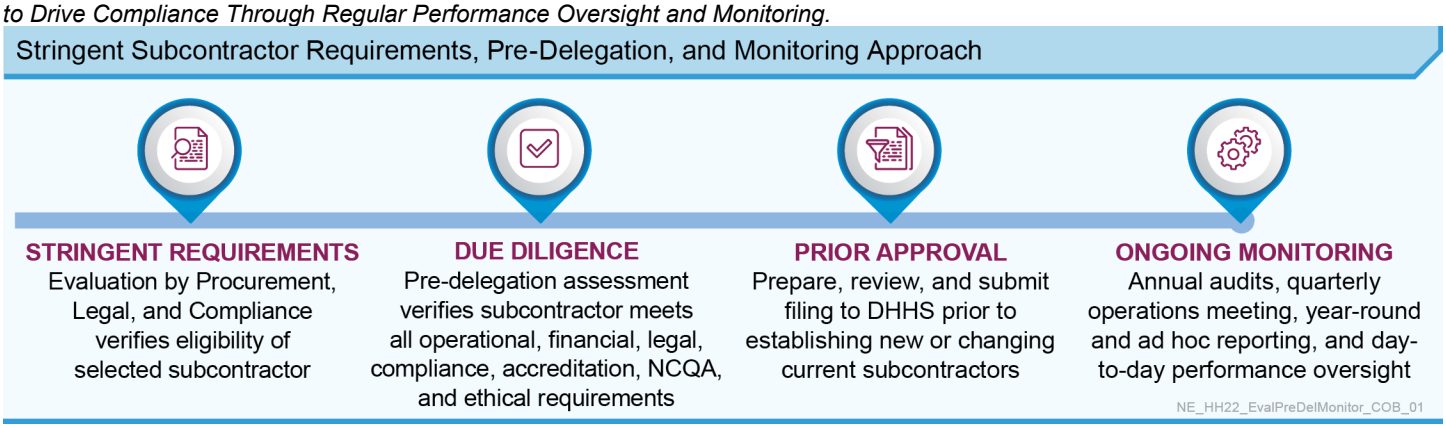
Healthy Blue's subcontractor relationships provide a seamless experience for members and providers. We collaborate with our subcontractors on the development and use of criteria and clinical practice guidelines based on nationally recognized, evidence-based practices, which go through the same review and approval processes as our internal guidelines.

Leveraging the unified capabilities of our enterprise, Healthy Blue and our subcontractors provide members with the most supportive, innovative, and fully integrated managed care model available. Our commitment to Whole Person Health and connected care assures that, even in delegation, we have a fully supported connection.

Subcontractor Vetting

Prior to selecting a subcontractor, Healthy Blue evaluates each prospective subcontractor's ability to perform activities to be delegated a minimum of 90 days prior to the planned Contract Start Date, and we invite MLTC to participate in these evaluations. We will submit a copy of our findings to MLTC at least 30 days prior to the Contract Start Date. We will monitor and formally review each subcontractor's performance on an ongoing basis. Figure V.K.50-1 provides an overview of our evaluation and ongoing monitoring approach.

Figure V.K.50-1. Our Comprehensive Subcontractor Oversight Program Begins with Thorough Vetting Prior to Selection and Continues to Drive Compliance Through Regular Performance Oversight and Monitoring.



Before any written agreements are established, we evaluate subcontractors for their ability to respond to and support members in an effective, efficient way. We thoroughly screen subcontractors, using our internal regulatory guidelines, policies, and procedures. Health plan leadership, including our Contract Compliance Officer and our national partners' Procurement and Legal teams, participates in subcontractor screening for necessary expertise, experience, and capabilities to meet all program requirements.

Healthy Blue applies a number of pre-delegation metrics, assessments, and evaluations when selecting subcontractors.We use a rigorous process for subcontractor selection and conduct assessments, including audits and reviews of the following:

- Operational capabilities, including analysis of a subcontractor's current and future contractual commitments and organizational resources, review of technology and system capabilities, conducting on-site visits and readiness reviews, and review of operational policies and procedures
- Performance record that incorporates review of each subcontractor's quality oversight policies and procedures and review of performance outcomes achieved for similar contracts
- Subcontractor references
- Understanding of applicable standards (for example, standards for claims payment) and delegated tasks
- Financial stability with review of audited financial statements, including statement of revenues and expenses, balance sheets, cash flow, unaudited year-to-date financial statements, and actuarial opinions of incurred but not reported expenses
- Fraud, waste, and abuse violations
- State and federal lists of providers and entities currently debarred
- State licensing and certification requirements, including review of regulatory compliance history, registrations, exclusions, terminations, sanctions, CAPs, and associated performance improvement plans
- Adherence to NCQA subcontractor standards

Our pre-delegation audit confirms that the proposed subcontractor organization meets Healthy Blue and MLTC operational, financial, legal, compliance, regulatory, accreditation, and ethical standards.

For subcontractors that provide direct services (for example, behavioral health, dental, vision, transportation, pharmacy), we perform pre-delegation audits prior to finalizing their subcontracts. In addition to the items already identified, we examine the organization's HIPAA privacy and security compliance, operating procedures, staffing ratios, and financial viability.

We make sure our evaluation methods include criteria reflecting members' unique needs. The subcontractors we work with today in Nebraska — and those we intend to use moving forward—have been fully vetted for their ability to respond to and support members in an effective, efficient, and caring way.

While Healthy Blue may delegate the authority to perform a specific function to a subcontractor, administrative oversight is never delegated. We are accountable and responsible for making sure the performance of all functions complies with contractual and applicable federal, state, and accreditation standards.

Developing Subcontractor Agreements

Our Procurement team partners with both the Nebraska leadership team and other subject matter experts within our National Medicaid organization to develop subcontractor agreements. These agreements incorporate all contract requirements: local, State, and federal rules and regulations, which include monthly monitoring of state and federal provider exclusion lists and Healthy Blue standards, policies, and procedures.Subcontractor agreements are additionally reviewed by the local health plan leadership, and our Legal, Compliance, Finance,Security, and IT teams.

Our process assures each subcontractor agreement meets the requirements of 42 CFR 434.6; provides an option for revoking delegation or imposing other sanctions if performance is inadequate; complies with all Nebraska statutes; and is subject to their provisions. We clearly communicate all requirements and expectations in each agreement, defining roles and responsibilities including activities and required reporting, outlining all procedures, plans, and policies for compliance, and incorporating all performance standards to be followed, including:

- Supplier code of conduct
- Supplier reimbursable expense guidelines
- Procurement process technology and electronic signatures
- Requirements for on-site personnel
- Business associate agreement (BAA)
- Medicaid requirements
- Performance and service measurements and direction
- Required industry accreditations
- Quality assurance requirements
- Financial responsibilities
- Hold-harmless provisions
- Insurance requirements
- Privacy and security requirements
- Data exchange and reporting requirements
- Record retention
- Right to audit

We assure all our subcontracts are approved by MLTC prior to execution. At least 120 calendar days prior to implementation, Healthy Blue submits all subcontracts, BAAs, and data sharing agreements for the provision of any services under this contract to MLTC for review.

Subcontractor Training

As part of the onboarding process, we provide training to orient our subcontractors to the Heritage Health Program and Healthy Blue's mission, vision, values, and operating procedures. We align subcontractor training goals with Heritage Health program training goals. Subcontractor training includes:

- MLTC policies, procedures, and contractual requirements
- Covered benefits
- Enrollment, including number of enrollees and eligibility
- Continuity of care period
- Unique medical and behavioral health characteristics of individuals of all ages with disabilities
- Fraud, waste, and abuse training
- Training on protected health information (PHI)/personally identifiable information (PII), securing PHI and PII, and reporting improper disclosures of PHI or PII
- Cultural and linguistic competency

Our subcontractors also have access to online training resources via Healthy Blue's Medicaid Training Academy, which includes an extensive library of training and continuing education opportunities. We regularly add presentations, videos, and other training documentation to this library to update our subcontractors and providers.

We continue to provide subcontractors with timely updates to processes and procedures and are available to deliver additional training, as needed, throughout the life of the contract. Trainings include a continuing medical education offered module on "My Diverse Patients" to improve the patient experience and trainings on cultural competency and patient engagement.

Ongoing Performance Oversight and Monitoring

We develop, maintain, and regularly update subcontractor oversight policies and procedures at both local and enterprise levels. Our subcontractor oversight activities are informed and guided by these policies and procedures, which apply to clinical and non-clinical subcontractor arrangements. Our staff is educated on these policies and procedures, which guide day-to-day interactions and our subcontractors also receive training on relevant policies and procedures.

Our well-established comprehensive oversight process assures our subcontractors are compliant and able to effectively deliver services to our members and providers. Our delegated oversight team monitors the performance of our subcontractors using a standardized process customized to fit the requirements of the contract and the type of work performed.

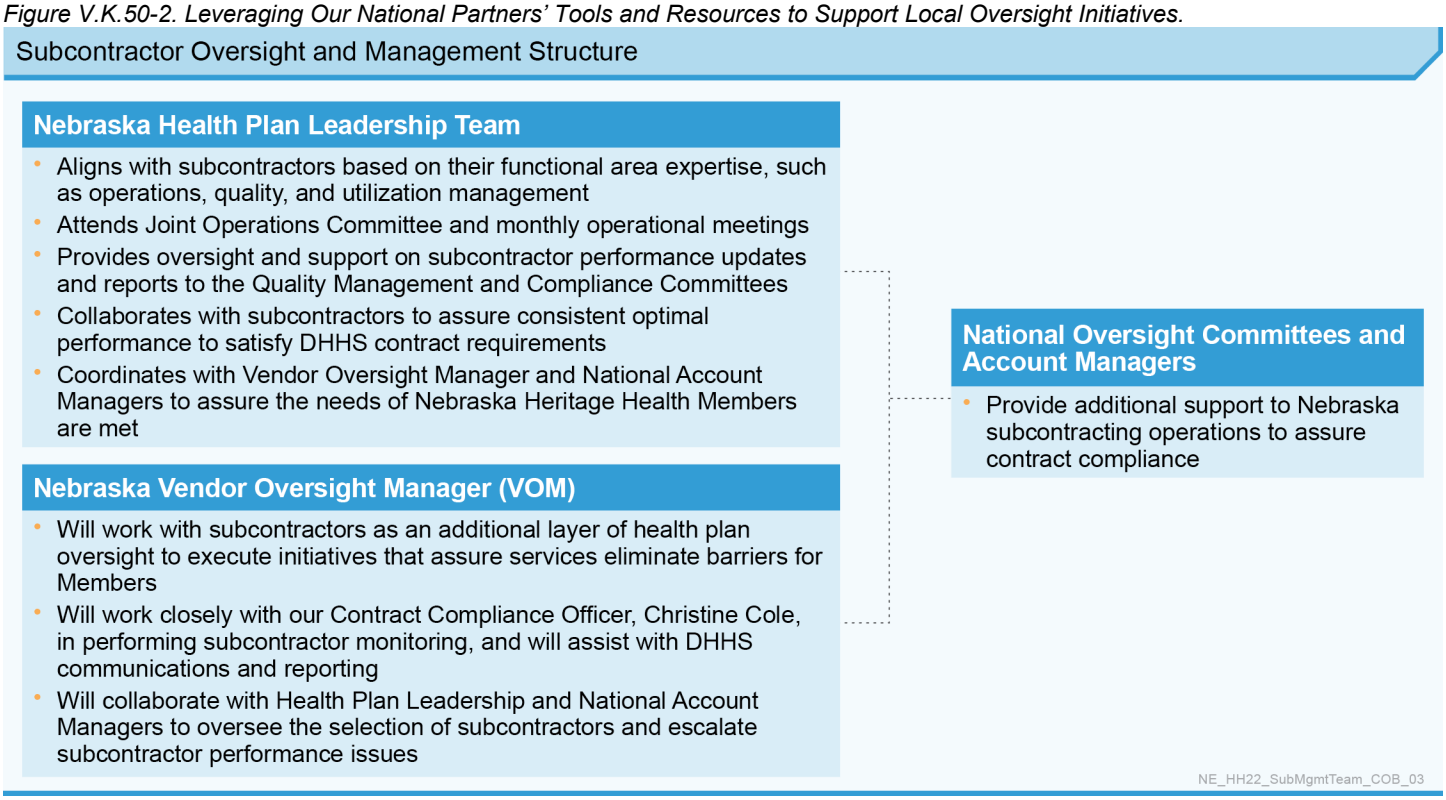
Local Vendor Oversight Manager

Our local VOM will oversee subcontractor performance, assuring each is compliant with all contract requirements. The VOM will serve as a liaison between MLTC and our subcontractors to assure performance issues are directly communicated and appropriately escalated. The VOM will have various responsibilities, including but not limited to:

- Cultivating strong relationship with each subcontractor
- Facilitating subcontractor performance reviews and reviewing audit results
- Working with subcontractors to resolve member complaints and grievances
- Escalating contract changes or performance issues and providing support through resolution
- Serving as a single point of contact for subcontractors and MLTC

The VOM will also receive support from our national organizational resources that add an additional layer of performance monitoring. This approach will provide accountability and transparency between our organization and subcontracting partners and help prevent compliance and quality issues. This structure maximizes effectiveness in monitoring performance, enhancing accountability, and avoiding compliance issues. Figure V.K.50-2 demonstrates our subcontractor oversight and management structure.

Figure V.K.50-2. Leveraging Our National Partners' Tools and Resources to Support Local Oversight Initiatives.



Subcontractor Performance Reporting

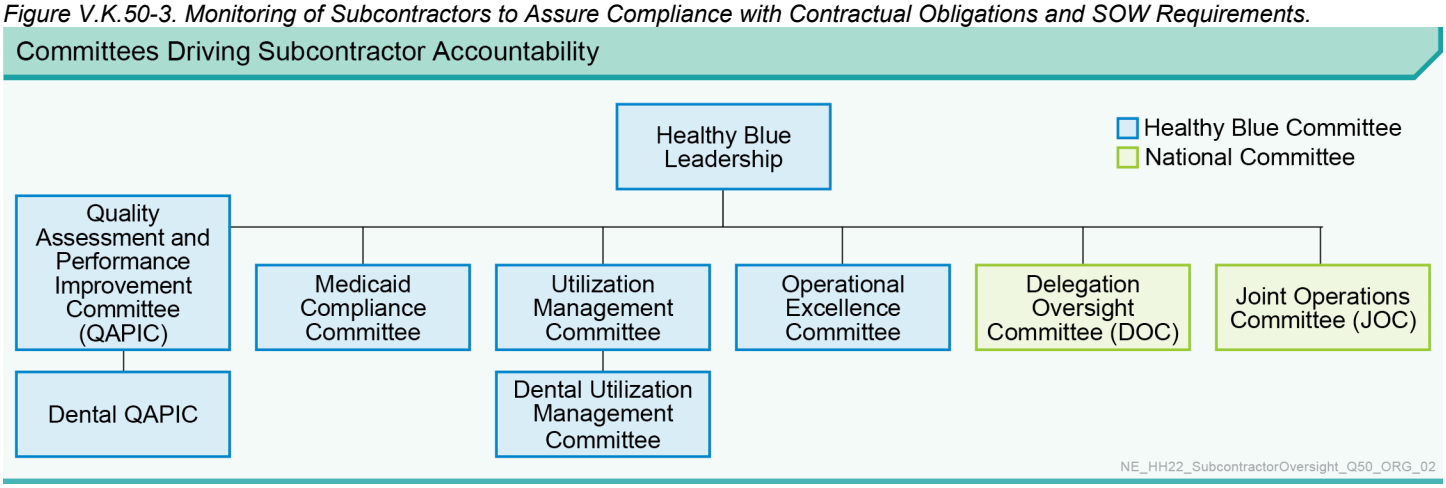
Ongoing operational performance monitoring is accomplished through a variety of means, including a subcontractor performance scorecard that enables us to monitor for trends, identify deficiencies, and measure clearly identified key performance indicators against Nebraska Medicaid targets. Performance reports are unique to each subcontractor and include key performance indicators (KPIs) that are developed in line with the services being performed. For example, the performance scorecard of our Non-Emergency Medical Transportation subcontractor incorporates KPIs that enable us to evaluate service utilization, trip mode, trip reason, on-time performance, timeliness of claims payment, call center data, grievance and appeals data, and reporting on fraud, waste, and abuse. Performance reports are reviewed monthly, with year-over-year data used to perform trends analysis to identify performance issues. We perform thorough analysis of this data to identify potential anomalies, which may trigger a focused review.

We measure performance for all subcontractors, whether they perform direct services to members and providers or produce products and services enabling Healthy Blue to communicate with members and consistently deliver timely, quality services. For example, we receive monthly performance reporting from our ID card vendor. We measure the following KPIs for this vendor: application and platform availability, Web services availability, Web services platform, response time, mail date reporting availability, production routine, daily volume commitment and turnaround time, privacy incidents, and production quality against client material specification. We measure each vendor against a specific set of KPIs tailored to the services they provide on an ongoing basis.

Committees Monitoring Subcontractor Performance

Our responsive committee structure provides a comprehensive framework for subcontractor oversight. Healthy Blue's committees, supported by our national enterprise committees, provide rigorous ongoing oversight of all subcontractors. Continuous monitoring and evaluation enable us to drive performance improvements and deliver service excellence. Figure V.K.50-3 illustrates the committees that drive subcontractor performance and accountability.

Figure V.K.50-3. Monitoring of Subcontractors to Assure Compliance with Contractual Obligations and SOW Requirements.



The following committees demonstrate our capacity to provide governance and oversight of subcontractors' operational performance. These committees review audit and operational performance data to drive discussions concerning performance improvement with health plan leaders and other national Medicaid Division partners:

- **Operational Excellence Committee.** We launched an Operational Excellence Committee in Q2 2022 with responsibility for governance and monitoring to deliver short-and long-term solutions continuously raising the bar on our performance. This committee includes members representing all areas of the health plan and national support services. The committee is charged with rapid responsiveness to member and provider issues, proactive approach to monitoring trends, improved transparency and communication with state partners, improved transparency and communication with providers, subcontractor oversight and integrated clinical relationship. The Operational Excellence Committee reports to the health plan executive leadership, and ultimately, our CEO, Robert Rhodes, MD.
- **Delegation Oversight Committee.** Routinely evaluates the performance of delegates against contractual requirements and local, state, and federal regulatory requirements, and all other operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements.
- **Joint Operations Committee (JOC) Meetings.** This forum evaluates subcontractor performance across all Medicaid markets in which they operate to identify areas for improvement and introduce best practices identified by the National Medicaid Division to our Subcontractor Oversight program.
- **Quality Assessment and Performance Improvement Committee (QAPIC).** This forum assesses the effectiveness of subcontractors' QM programs. Amongst other responsibilities, the QAPIC reviews subcontractors' denial trends, reviews utilization trends to monitor for possible over- or under-utilization of services and evaluates subcontractors' utilization management (UM) program. We will also have a Dental QAPI Committee that specifically addresses dental quality and performance.
- **Utilization Management Committee (UMC).** Chaired by our Chief Medical Officer, Dr. Debra Essar, and our Case Management Administrator, Tamara Mostek, our UMC oversees all UM and SDOH program activities and processes, including delegated clinical services. The committee reviews, monitors, and evaluates subcontractor UM program compliance with Healthy Blue standards, state and federal laws and regulations, contractual requirements, and NCQA standards. As such, our UMC makes sure health care services delivered to our members via a subcontractor are at appropriate levels.
- **Dental Utilization Management Committee.** We will be introducing a Dental Utilization Management Committee to provide utilization review and monitoring of dental UM activities. Our Dental Utilization Management Committee will be chaired by our dental director and will monitor the dental appropriateness and necessity of health care services, review the effectiveness of the UM process, and make changes as needed, monitor over-and under-utilization of services, and approve dental UM policies and procedures.
- **Medicaid Compliance Committee.** Conducts executive oversight of the Medicaid Compliance program and supports the Medicaid Compliance Officer. This committee reviews, discusses, and monitors significant compliance risks, including those tied to subcontractor performance. The committee also reviews and discusses reports received from various stakeholders including but not limited to the Medicaid Compliance team, Internal Auditors, external auditors, Special Investigations Unit (SIU) liaisons, and Legal. Reports received may address subcontractor performance.

Our subcontractor oversight program includes multiple touch points to monitor and evaluate subcontractor performance as shown in Table V.K.50-1.

Table V.K.50-1. Timing and Activities to Monitor and Evaluate Subcontractor Performance.

Timing	Subcontractor Monitoring Activity
Daily	▪ Healthy Blue staff are available to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns.
Monthly	▪ During monthly operations meetings, Healthy Blue staff review subcontractor performance against standards (including trends) and report submissions.
Quarterly	▪ Review performance with subcontractor during JOC meetings. ○ In addition to performance metrics, JOC meetings also provide an opportunity to review HEDIS®, health plan-specific initiatives, any applicable CAPs, and quality improvement goals. ▪ Report subcontractor updates including additions, terminations, and performance issues to the QAPIC.

Timing	Subcontractor Monitoring Activity
	▪ Operational Excellence Committee oversees multiple operational departments and includes representation from the subcontractor oversight area. ▪ Report and discuss any quality issues with subcontractorperformance to the QAPIC. ▪ Discuss performance standards and metrics of subcontractors as well as new subcontractor additions,terminations, CAPs, and overall risk during Delegation Oversight Committee meetings. ▪ Review significant compliance risks caused by subcontractor performance during Medicaid Compliance Committee.
Annually	▪ Perform audits or review to confirm that subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements. ▪ Present audit findings to the QAPIC.

Subcontractor Auditing

Healthy Blue conducts rigorous, periodic formal subcontractor audits to verify compliance with contract requirements,as well as with other applicable requirements, including state and federal law. These audits assist in identifying areas for performance improvement and innovation. We communicate with our subcontractors to clearly define and describe improvements and innovations to optimize their performance. The following is a general overview of the audit process:

- Conducting formal desktop and on-site reviews
- Reviewing performance management reports
- Conducting audits of subcontractor performance against requirements
- Identifying and communicating deficiencies or areas for improvement
- Enforcing correction of any identified performance deficiencies or termination if deficiencies cannot be corrected

For subcontractors that bear financial risk or deliver health care services directly to our members, we also conduct financial audits to assess the financial solvency of the subcontractor.

When issues of partial compliance and/or non-compliance are identified, the delegate must correct these deficiencies within a mutually agreed upon timeframe. Audit results are presented to appropriate Nebraska Medicaid committees for review, evaluation, and implementation of any necessary opportunities for improvement or corrective action. Information acquired from subcontractors during the audit process is available to MLTC upon request.

Oversight Policies and Procedures

We maintain policies and procedures to assure our subcontractors fully comply with all applicable terms and conditions of the contract. As part of our efforts to assure that our subcontractors comply with all contract requirements related to the functions that have been delegated to them, we regularly provide them with oversight policies and procedures, as well as policies and procedures applicable to the delegated functions they perform. Where a subcontractor is not delegated a specific function but has a role to play, we also share applicable policies and procedures, as is the case with member grievances. Informing our partners of our oversight policies and procedures is only step one in the process to assure full compliance with contract requirements. We provide proper education on policy and procedure content to verify full understanding of expectations.

Mitigating the Risk of Subcontractor Performance Issues

Performance Guarantees

We use performance guarantees as a tool to help assure our subcontractors meet required contractual performance standards. For example, we are aligning the performance guarantees in our Non-Emergency Medical Transportation (NEMT) subcontractor's contract with the SOW, including the NEMT Provider Service Requirements (SOW E.29.i). In addition, we develop and include performance guarantees tied to KPIs developed internally. To develop these unique performance guarantees, we leverage our national experience and introduce metrics indicative of subcontractor performance. For example, we also include performance guarantees in NEMT subcontractor agreements tied to the percentage of completed trips.

We include a financial risk component for one-time and repeat non-performance in our subcontractor contracts that span a variety of performance areas, including but not limited to the following:

- Call center
- Claims processing
- Complaint, grievance, and appeal resolution
- On-time performance
- Encounter timeliness and accuracy

When subcontractors significantly exceed contractually required performance standards, we provide a financial incentive for consistent service excellence.

Taking Corrective Action

Healthy Blue works daily to identify and discuss resolution of performance issues early — before they become a problem. We supplement our proactive Subcontractor Oversight program management structure with robust monitoring, including monthly performance reporting, quarterly reviews, and annual audits that enable us to identify subcontractor performance issues.

When we identify subcontractor deficiencies, we initiate a CAP and emphasize the need to evaluate and implement meaningful change. After our Contract Compliance Officer reviews and approves the CAP, we monitor subcontractor compliance and achievement of milestones by specified due dates. We set controls by engaging in weekly or monthly (or as set forth in the CAP) meetings with the subcontractor, depending on the severity of the issue. During committee meetings, we review the action plan to monitor progress for each action item. We discuss accomplishments, as well as areas of concern, including any risks of not meeting a deadline.

If it becomes apparent that CAP implementation is not addressing areas of concern as expected in a reasonable timeframe (typically 90 days), committee representatives and executive leadership determine the risk of the subcontractor's ongoing non-compliance. Depending upon its severity, our Legal department may also be involved. If the subcontractor is unable to resolve the issue or comply

with contract provisions and it becomes apparent that CAP implementation is not addressing areas of concern as expected, we determine the risk of the subcontractor's ongoing non-compliance and take appropriate action.

The inability of a subcontractor to comply with contract provisions leads to progressive corrective action. In addition to initiating a CAP, we employ other means of enforcing contractual compliance including:

- Breach Notice
- Sanction
- Capitation deduction or withhold
- De-delegation of functions
- Contract termination

Oversight in Action

[redacted]

Quality and Service Excellence

Healthy Blue collaborates with our subcontractors to deliver high quality, responsive service to members and providers, meeting or exceeding all contractual requirements. Initial training, ongoing monitoring and evaluation, formal and informal reporting, and periodic discussions with our subcontractors assures continued compliance with our obligations. We also seek customer feedback and incorporate this information into our planning and performance improvements.

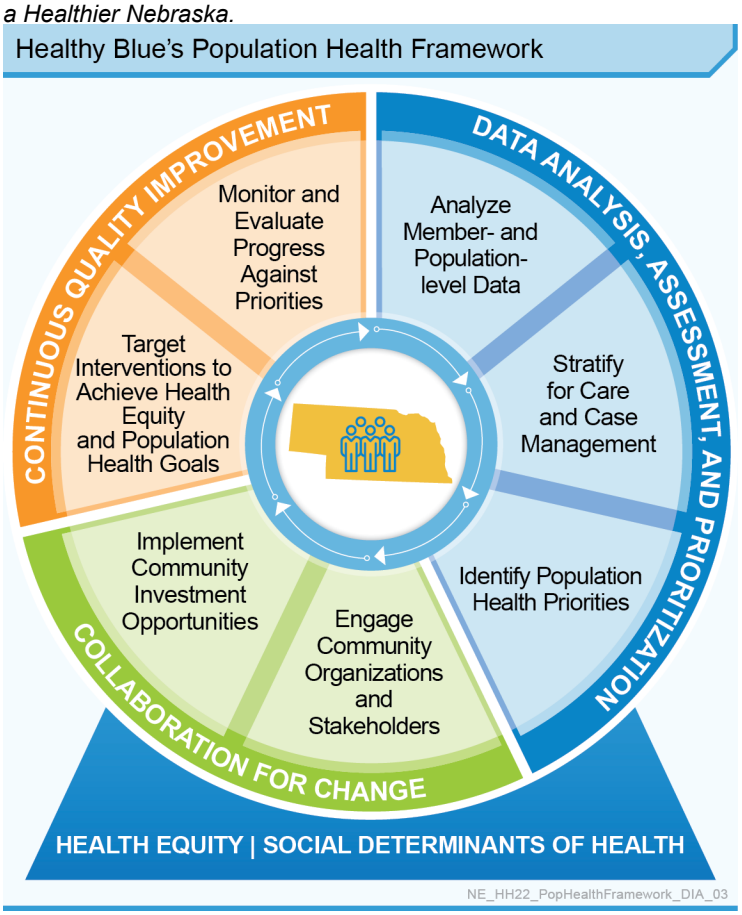
No. 51

Healthy Blue's Care Management Program: A Central Component of Population Health

Healthy Blue maintains a comprehensive care management program that complies with requirements outlined in RFP Section V.L. Care management and represents a central component of our population health model, which focuses on key priorities of the State, such as maternal health and asthma, to develop interventions that foster healthier, resilient communities while also addressing each member's individual needs. Care Management is carried out within this framework (as illustrated in Figure V.L.51-1), bringing together all functional areas to provide integrated solutions. It includes:

- ***Understanding our member population via data analysis, assessment, and prioritization to inform our goals and help us innovate programs***
- ***Collaborating with community-based organizations, members, and other stakeholders to achieve healthier communities***
- ***Conducting continuous performance improvement to refine our programs***

Figure V.L.51-1. Healthy Blue's Population Health Framework Fosters a Healthier Nebraska.



As a leader in care management, Healthy Blue promotes person-centered, whole person care to respond to all member needs and improve health outcomes. The program centers on collaboration between Healthy Blue, the member, their family, providers, and others who provide services to the member, including Home and Community-Based Services (HCBS) Coordinators. Our relationship building and engagement of all members begins at enrollment with a warm welcome and continues with a ***no wrong door approach***, so that members have multiple touchpoints to engage in care management.

Further, our care management processes are cross-functional, engaging our staff across the organization in developing and implementing comprehensive, culturally competent, and highly coordinated solutions to address member needs, including Care Management and Coordination, Member Services, Community Relations, Provider Network Development and Management, Utilization Management (UM), and Quality Management. Together, our staff use continuous process improvement strategies and data analytics to advance health equity and build capacity across the state through local partnerships with community and faith-based organizations. At the individual level, we design our data and assessments to capture members' holistic physical health (PH), behavioral health (BH), dental, vision, pharmacy, and social support needs — current and future — while addressing the impact of economic barriers, health care access, education, and environmental influences on health outcomes. ***Throughout every step of our approach, we keep members at the center, making sure we engage with each individual and connect them to the services and supports they need.***

Through our tenure serving Heritage Health, Healthy Blue has maintained NCQA accreditation and anticipates a Multicultural Health Care Distinction award in July 2022. ***Accreditation provides the structure and process for sharing best practices in care coordination and care management to drive improvements in member outcomes.*** Our parent organization holds NCQA Population Health Accreditation and full Managed Behavioral Health Organization (MBHO) Accreditation. It scored 100% on MBHO-associated standards, reflecting our commitment to following evidence-based practices for providing high-quality BH care, access, member protections, and integration at the health plan and practice levels. Population Health Accreditation is awarded to organizations that monitor and address opportunities and challenges in their populations and align their approaches in accordance with best practices. We leverage this NCQA-accredited BH and population health approach to provide services to Nebraska members in a seamlessly integrated manner through our local Care Management and UM teams.

As part of continuous and ongoing improvement, we routinely evaluate our care management program structure, processes, and resources. Annually, we submit our Care Management Program Description for review and approval through our Quality Management Committee. The Committee evaluates our program to verify that the scope, goals, performance measurements, and planned activities align with the State's priorities and the latest evidence-based practices. We have a long-standing history of maintaining a comprehensive Care Management Program Description, and our current description incorporates all requirements outlined in SOW V.L.

Moreover, our clinical and quality leadership conducts ongoing assessment of care management quality and health outcome indicators, such as HEDIS® measures, utilization metrics, CAHPS®, and other member satisfaction indicators, grievances and appeals, and other data points for emerging or persistent areas for improvement. Our goal is to make sure each member receives the most appropriate services — tailored to their needs — to achieve their health and wellness goals.

An Integrated, Skilled Care Management Team

Since 2017, we have served members with a committed and experienced team, based in the local community to reflect the local cultures and priorities across the state. To assure truly integrated care that addresses the whole person, Healthy Blue has one Care Management team — trained and skilled to identify a member's total health needs. Our organizational structure facilitates localized care management at the site of care, in the home, or in the community, while also equipping our system partners (providers or community-based organizations) with tools, analytics, and support to address PH, BH, and social needs of members. We provide resources to our Care Management team to make sure members are getting the right care — such as HCBS, telehealth, and multi-disciplinary care teams — in a culturally appropriate and responsive manner.

Our Chief Medical Officer (CMO), Dr. Debra Esser, oversees our care management program, which includes a multi-disciplinary team of clinical staff, Care Coordinators, Care and Case Managers (depending on the level of care management needed) to arrange, assure deliver, monitor, and evaluate the care, treatment, and services to members. With more than 35 years of clinical and leadership experience, Dr. Esser is a Nebraska-licensed, board-certified family physician who provides overall guidance in all aspects of care management, and works in close conjunction with Dr. Martin Wetzel, our Behavioral Health Clinical Director. A board-certified psychiatrist with 30 years of experience, Dr. Wetzel provides guidance on BH supports as part of the care management program. Together, Dr. Esser and Dr. Wetzel have devoted their clinical careers to serving Nebraskans. Both earned their medical degrees at the University of Nebraska. Our Medical Directors work in tandem with our clinical leadership, including our Health Equity Director, Quality Improvement Coordinator, Tribal Network Liaison, Case Management Administrator, Medical Management Coordinator, and others to make sure we fully integrate our interventions across every functional area (UM, quality management, and more).

Our clinical leaders are Nebraskans and skilled in person-centered principles who bring decades of experience. Each are engaged daily to meet the needs of our members through consultation and participation in a variety of clinical rounds, such as integrated rounds, which involve an interdisciplinary discussion of members' needs, available supports, and necessary services and interventions to inform care management actions. Integrated rounds help our clinical staff in developing innovative strategies to include in a member's care plan, determine the best path to support the member, and remove barriers to care. These rounds occur at least weekly, so that our clinical staff can quickly escalate unresolved issues or unmet member needs for resolution and solution. In addition to weekly rounds, our clinical team meets on an ad hoc basis to address urgent member needs that are best addressed by a multi-specialty team approach.

Coordination of Services Using Person-centered Strategies

Through our no wrong door approach, members have many opportunities to engage in care management, whether they call us for assistance, respond to an alert, or receive customized outreach for engagement based on their unique circumstances. For example, members and their families or caregivers can refer themselves for care management programs through our Member Services Call Center or work with any Healthy Blue team member to seek help with services or clinical concerns. In addition to training our staff (including Outreach Care Specialists, Peer Support Specialists, our Tribal Network Liaison, Care Managers (CMs), and others) to recognize the need for referral, we also educate our providers on how to refer members to our care management programs. Our discharge planning staff have real-time access to proactively refer members who are hospitalized for the appropriate care management levels. We also receive referrals from our community partners and State staff from the Office of Behavioral Health, Office for Citizens with Developmental Disabilities, Department of Children and Family Services, and other stakeholders.

Our person-centered approach meets members where they are, focuses on what they prioritize in their health journey, and adapts support and engagement as members' needs change. We understand that each member has unique needs with different paths to wellness, challenges, and stages of readiness to become active participants in their health. Cultural differences, values, and beliefs are key factors that inform and influence health behavior. We tailor engagement strategies from health coaching to care management, according to the member's needs and readiness to engage. Across our care management program — including Disease Management (DM), case management, and complex case management — we use multiple methods to reach and engage members, meeting them

where they are in terms of level of support and outreach, they may need. We proactively engage members, parents, and caregivers of members if appropriate, identified for the care management level of service, through telephonic, written, digital, and in-person engagement modalities that intensify as a member's needs increase or if they cannot be reached.

For example, we engage pregnant members based on their needs and preferences. To encourage and support pregnant members in completing their prenatal and postpartum care, we provide our Healthy Blue Pregnancy Application. The app tracks their appointments and sends twice weekly communications (including appointment reminders and assessment surveys) tailored to the member's pregnancy stage — from prenatal through 12 weeks postpartum. The tool includes a kick counter, provides fetal development images, and checklists. For pregnant members with more significant needs, we engage them in ongoing low- and high-risk care management programs to connect them to prenatal and postpartum visits, provide health education and coaching, and mitigate risk factors to promote a healthy mom and baby.

All members receive care management services that include prevention and wellness interventions, and then according to risk and need, they receive additional levels of services. For example, when we receive a referral, our Outreach Care Specialists and Medical Management Specialists review member needs and assign to a CM or Case Manager based on their needs. Following assessment, a member may qualify for and be stratified into a higher level of care management than they desire to participate. Thus, we work with members to develop a plan to meet their needs that aligns with the level of care and case management they desire, while using the assessment results to inform the development of a person-centered care management plan, support level of care decisions, and create the baseline for outcomes measurement. We assign a Care or Case Manager that has the background, skills, and expertise to match the member's need for services.

Our Care Management team is knowledgeable on all levels of care intensity within our Nebraska network and the community, which enables them to work collaboratively and continuously to match support to need. Further, care management staff receive training in motivational interviewing techniques to help build trust and rapport with members, so they feel comfortable sharing potentially sensitive information. ***In addition to motivational interview training, our CMs receive person-centered thinking training, a two-day course by The Learning Community for Person-Centered Practices. Five of our licensed clinicians have also completed the Case Management Society of America's Integrated Case Management Training.***

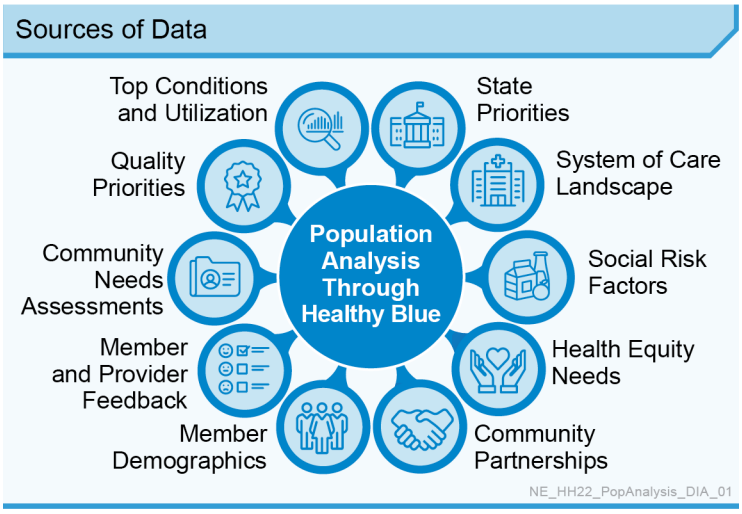
Our CMs collaborate with members to determine the types and frequency of contact that best meets their needs. We also focus on supporting members and their families to identify their personal goals and desired outcomes from participation in care management programs. This includes talking with them about the people who are important to them, how they like to spend their day, work or volunteering they like to do, and where they want to live. Using motivational interviewing techniques, person-centered planning principles, and trauma-informed practices, the CM helps the member identify personal short- and long-term goals, preferences, needs, and desired outcomes. CMs work with members to establish goals and preferences in their own words using tools such as our Person-centered Planning Guide. They explain the types of care, services, and supports available to meet the member's needs, including carved-out services and services from other programs, such as social or educational services, so that the member or family can choose those they want and are important to them.

The care plan clearly outlines the member's relevant history, health status, support system, and wellness goals, and communicates the role each person, provider, or service plays in helping the individual achieve those goals, along with personal details such as crisis plans to facilitate a focused, individualized response at any level of care. It identifies all members of the multi-disciplinary team and their contact information. The care plan is organized around evidence-based clinical practice guidelines, which the CM supports by confirming that the member is keeping appointments, completing appropriate screenings or lab work, and engaging in self-care activities as outlined in the plan. In addition, CMs educate members and caregivers about available services so they can choose those that best meet their needs and preferences. Our care plan aligns across all levels of service, with increasing details and higher levels of interventions based on level of service, whether DM, case management, or complex case management.

Multiple Data Sources That Help Inform Our Person-centered Strategies

In addition, we leverage and integrate data from multiple sources, turning it into actionable information that provide in-depth insight that helps us identify members who may be at risk for developing more serious health conditions. Our approach to risk stratification for care and case management interventions considers multiple factors and is not solely based on clinical indicators.
Examples of data sources are outlined in Figure L.V.51-2, below:

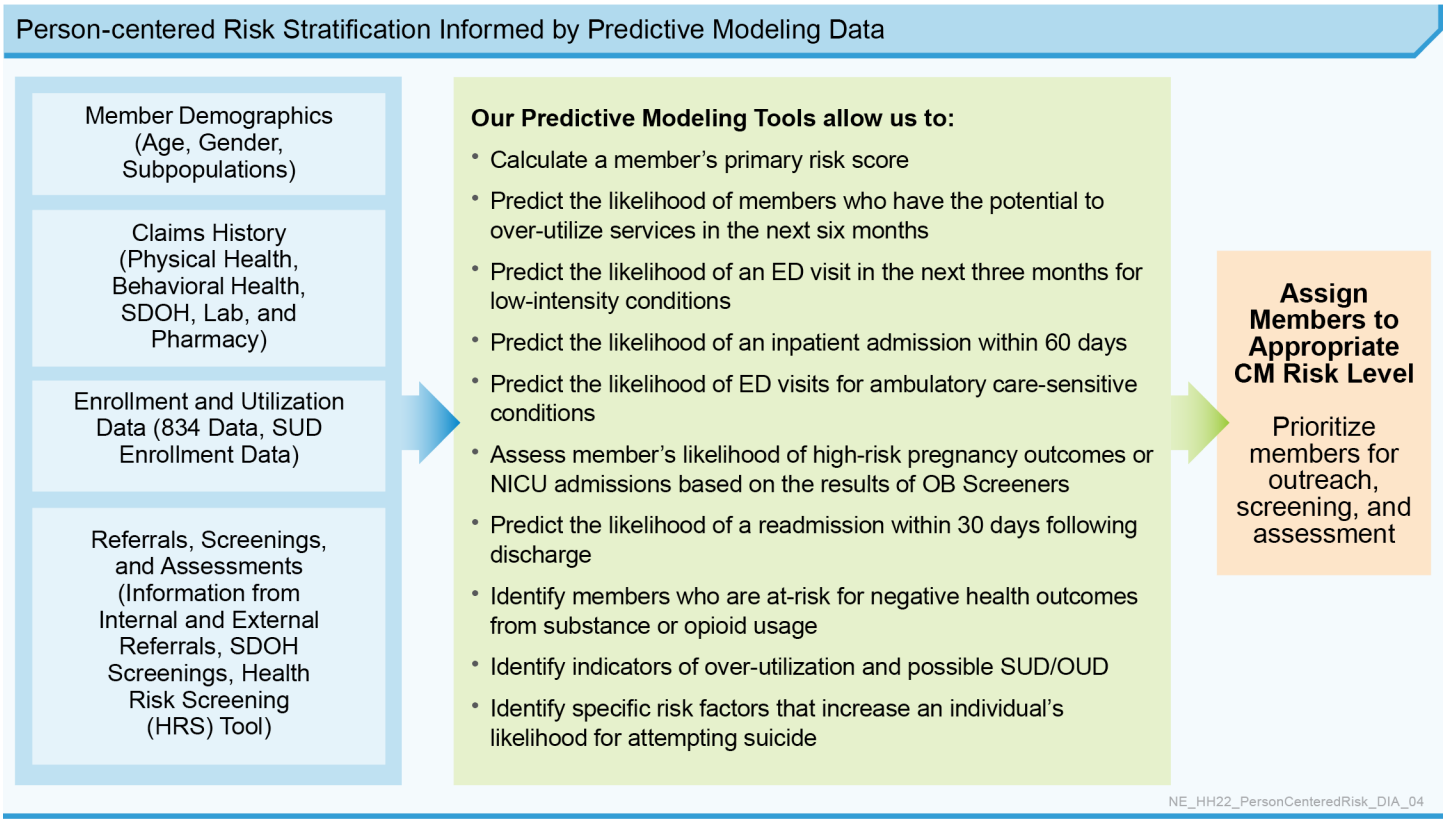
Figure L.V.51-2. Healthy Blue Leverage Multiple Data Sources for Insight Into Member Health.



In addition to the Health Risk Screening and Health Risk Assessments, we use predictive modeling and analytics that have been built to assess the complex interactions of physical, behavioral, and social factors continuously and systematically in the delivery of health care. We use risk stratification to help determine the level of support members may need (Figure V.L.51-3). We recognize a member's risk level may be influenced by a wide array of factors — diagnosis, treatment history, family and other supports, and unmet social needs. Thus, we blend well-honed predictive modeling tools with a thorough analysis of diverse sets of demographics; claims data; admission, discharge, and transfer (ADT) and electronic health record data; data available from screenings and assessments; and information shared by members, their families and caregivers, and providers. We use algorithms identifying types of risk, including:

- **Chronic Illness Intensity Index.** Main component of our predictive modeling system that calculates a risk score for each member.
- **Readmission Risk Assessment Surveys (RAS).** Analyzes inpatient daily census reports to determine the likelihood of readmission within 30 days post-discharge.
- **Emerging Risk Model (ERM).** Identifies members with the highest risk of increase in utilization within the next six months.
- **Low-Intensity ER (LIER) Utilization Risk.** Predicts the likelihood of an emergency department (ED) visit for low-intensity conditions within the next 90 days.
- **Likelihood of Inpatient Admission (LIPA).** Uses utilization, diagnostic, and demographic data to predict the LIPA within 60 days.
- **Statistical Obstetrical Risk (STORK) Score.** Predicts a pregnant woman's probability of delivering an infant that will require the NICU based on our OB risk screening tool.
- **Suicide Prevention Outreach Team (SPOT).** Supports adults (27 and older), adolescents, and young adults (12 to 26) who are at high or critical risk for a first or subsequent suicide attempt over the next 12 months. Key predictors include a history of suicidal ideation, substance use, mental health diagnosis, and survivor of trauma or abuse.

Figure V.L.51-3. Healthy Blue's Risk Stratification Uses Predictive Modeling and Data Analytics.



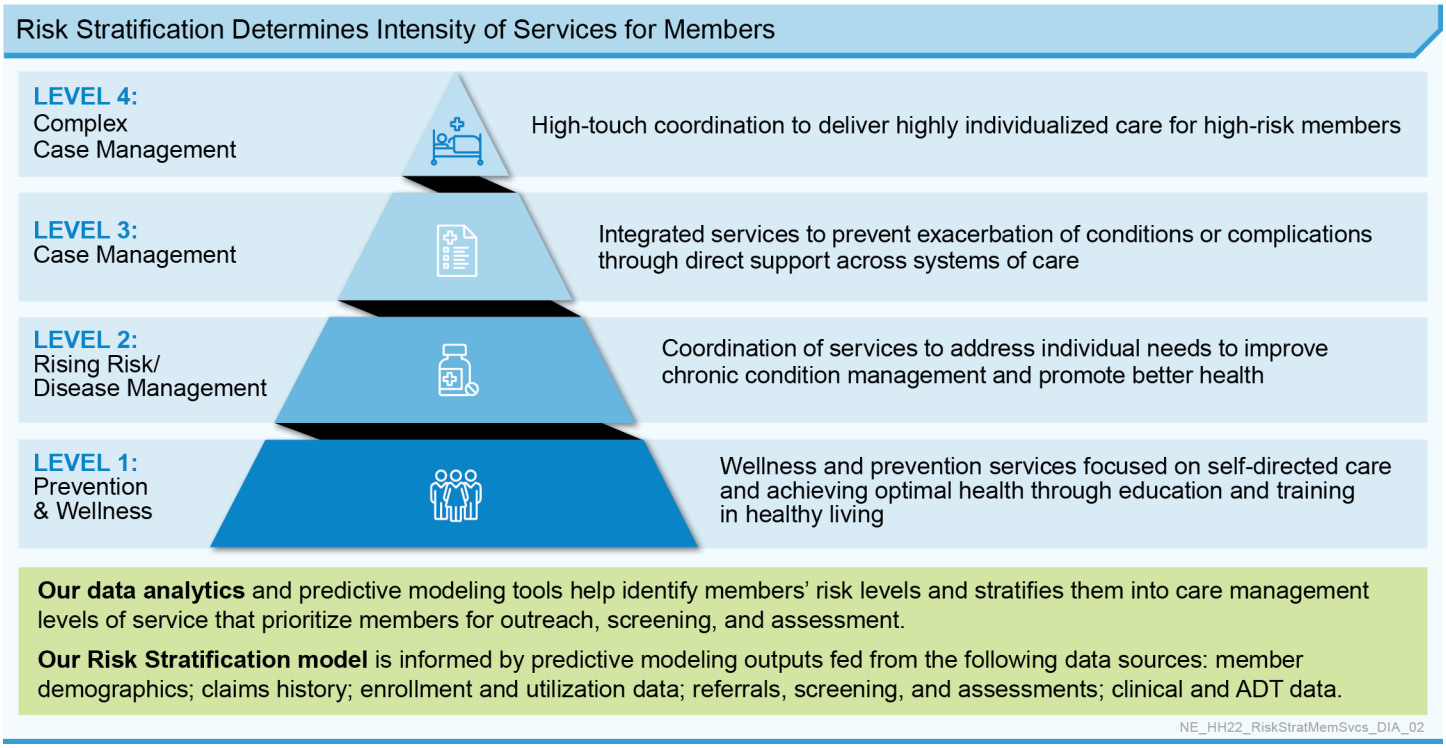
Interventions Focused on the Whole Person

Our approach to whole person health echoes the continuum of care management: health promotion and wellness, management of chronic conditions, and complex case management. We assign members to a BH or medical CM based on their levels of PH and BH complexity and track care and UM activities. At all points in care management, our team collaborates to address members' health and social needs and identify solutions to the barriers they may face in improving their health and achieving their personal goals.

Our care and case management interventions focus on the whole person and empower members to participate with their medical home, Dental Home, specialists, and other care providers to effectively manage health conditions and prevent complications by making healthy lifestyle choices, adhering to medication regiments, attending regular preventive care appointments, and self-managing strategies to improve chronic disease. Across all interventions, we meet members where they are in their health journey, connecting them to benefits, services, and resources that will best meet their individual needs and goals, paying close attention to any health disparities or inequities that need to be overcome. To improve engagement, our whole person care management approach accounts for member physical, behavioral, and social needs, while recognizing and addressing their cultural differences. We learn all members' preferred method of communication and note it for all outreach. Healthy Blue team members are trained to explore cultural preferences throughout engagement activities to incorporate member feedback and their understanding of their conditions throughout engagement, communication, and care planning activities.

Figure V.L.51-4 highlights the four risk levels and interventions we use, including prevention and wellness, DM, case management (including discharge management), and complex case management. While risk stratification helps to predict a member's needs, we understand it does not replace the clinical judgment of trained and licensed clinicians. Our whole person approach recognizes each member's risk is affected by more than a diagnosis. We consider acuity level, self-management skills, health care system navigation skills, natural supports (personal relationships such as family, caregivers, and close friends), unmet social needs, geographic location, and more to identify the appropriate level of support needed. Care or Case Managers may change a member's stratification level based on additional information received during screenings or assessments, information sources, and data analytics, as well as from discussion with our Medical Directors and Healthy Blue's Integrated Rounds. Using the results from risk stratification and following evidence-based levels of service criteria, augmented by the clinical judgment of our licensed Care and Case Managers, we place members in Tiers 1 through 4 and further prioritize needs within those levels of service.

Figure V.L.51-4. Healthy Blue's Whole Person Interventions at Every Level of Risk and Need.



Risk Level 1 (Prevention and Wellness Interventions)

In Risk Level 1, all members receive prevention promotion and wellness empowerment services designed to help them engage with their PCP and other providers and complete timely immunizations and preventive care.

Risk Level 2 (Rising Risk/Disease Management)

In Risk Level 2, our DM program focuses on helping members with chronic conditions build self-management skills with support from our Care Coordinators and Health Educators, while promoting adherence to evidence-based care and services. Our Care Management team is highly skilled and trained in verifying each member's PH, BH, functional needs, and social support needs are addressed. With an understanding of each member's needs, our CMs can address potential barriers to care, such as coordinating transportation to appointments or working with the UM team to authorize extended services when indicated, or proactively building a member's knowledge about diabetes self-care. We train our staff on key evidence-based practices, such as trauma-informed care and motivational interviewing, to get to root causes. Often, this results in relinking the member to a provider or PCP, resolving issues with transportation or medication adherence, or connecting the member to community supports.

Risk Level 3 (Case Management)

Risk level 3 incorporates case management to help members to develop person-centered care plans focused on the member's self-identified needs and gaps in care. Services focus on assisting the member in navigating the health care system and care transitions between settings, as well as collaboration with physicians, community resources, and natural supports in implementing their plan of treatment. We support members in optimizing the use of their benefits to obtain high-quality health care across all health care settings. Our Case Manager uses skills in motivational interviewing to encourage the member to create and achieve specific and attainable goals toward improved health behaviors. We coordinate these health care goals across all settings using evidence-based best practices. Care plans integrate members' PH, BH, and social needs, which include multi-disciplinary internal program clinicians and external providers of care.

Risk Level 4 (Complex Case Management)

The fourth level of our care management program serves members identified with complex care needs. Through this care, we strive to deliver optimal value for members by objectively improving health, function, safety, and member satisfaction, empowering members to self-manage through education and support, and identifying and closing barriers to care to improve member well-being. Our program model is centered around whole person integrated care. Please refer to our response for question 53 for specific types of interventions and services members receive by risk level.

REAL STORIES

Twenty-three-year-old **Lucy**, an enrolled member of Healthy Blue, has a history of C1-C4 angioedema, neuromuscular dysfunction of bladder, and depression, and was recently diagnosed with quadriplegia, which qualified her as eligible for the Aged and Disabled (A&D) Waiver. Lucy was residing in a Rehabilitation Facility and while her needs originally aligned with our Care Management Level 3, she was elevated to Level 4 based on her recent increase in symptoms. Lucy's assigned CM, Henry, shared medical records and obtained updated records from the facility that would assist Lucy's mother, Margaret, in completing the A&D Waiver application, while working with them to identify how Healthy Blue could further meet Lucy's and her family's transition and ongoing needs during the application review waiting period.

Henry was very aware of the challenges associated with a member being ready for discharge and the availability of an appropriate environment that supports a safe, successful, and long-term transition. Because Margaret had a family member who was a construction contractor, she engaged him to complete home modifications that she wanted in the family home. This included a included a temporary ramp, enlargement of the front door entry, and bathroom accommodations. Honoring the family's decision to move forward with their own home modifications, Henry assisted in engaging the League of Human Dignity to work with them to complete an evaluation of the safety of the completed modifications and in identifying and addressing any additional needs for Lucy.

Henry also worked with Margaret on developing a comprehensive, patient-centered care plan that identified additional needs for Lucy, including a hospital bed, shower chair, and Hoyer Lift to assure Lucy's safety and quality of life. To address the family's SDOH needs, Henry arranged adaptive transportation to appointments, engaged a nearby church community for assistance with yard work and home delivered meals, and access our Transportation Essentials VAS for a gas card for Margaret.

Lucy is living comfortably at home and has not had any additional admissions. While her Waiver approval is pending, Margaret and Lucy are attending counseling together, and other family members have been trained in and are assisting with Lucy's care to provide Margaret with needed breaks. Henry continues to assure approval of ongoing services requiring authorization and routinely checks in with the family and adjusts Lucy's care plan as she reaches her goals, or the family identifies additional needs.

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Management of Co-morbidities (including SUD)

As part of our overall integrated care management program, we proactively identify and address each member's unique needs, strengths, and goals in consultation with the member, CM, supports, and treating providers. This includes assisting members with managing their comorbid conditions, rather than solely focusing on the primary condition. We recognize that many members with complex or comorbid conditions experience both medical and BH conditions. To appropriately manage the co-morbidities using our fully integrated approach, we:

- Maintain a strong care management team of highly qualified PH and BH clinicians and support staff (including Peer Support Specialists) who are trained and licensed to address a member's whole health needs
- Make sure our care management team has comprehensive knowledge of key benefits and service delivery models and works closely with the provider and hospital communities to facilitate patient-centered communication, treatment goals, and care planning
- Conduct specialized case rounds that give clinical staff an opportunity to meet with our Medical Directors to consult regarding members with specialized, complex, comorbid, or co-occurring conditions. This collaborative approach provides the team with an opportunity to develop innovative strategies to include in the member's care plan and determine the best path to support the member and remove barriers to care
- Incorporate a variety of evidence-based models specifically designed for individuals with comorbid or chronic PH and BH conditions

Our field-based CMs perform care management, within their scope of licensure, for members with complex and chronic care needs including BH and comorbid conditions. They assess, develop, implement, coordinate, monitor, and evaluate care plans designed to optimize member health care across the care continuum. Our program is sensitive to BH issues and can readily facilitate the identification of members with co-occurring physical and behavioral health needs who require enhanced health care services through our predictive models, health needs assessments, or as members are screened and assessed by providers. We obtain consent after appropriate services have been identified so providers may know of a member's entire health care need — past, current, and emerging — so that we can provide the care each member requires.

We also provide comprehensive resources and direction regarding the availability of services to providers so that they can make appropriate referrals, as indicated. Healthy Blue uses high-touch care and case management strategies to facilitate continuity of care from setting to setting assuring successful transition of members from nursing homes, correctional facilities, and other institutionalized care. For example, as we identify a member who has screened positive for BH needs in primary or urgent care settings, our Care Management team members, including our field-based Outreach Specialists or CHWs, will coordinate with providers to support the level of care needed.

Addressing Members with SUD

Our BH team comprises more than 20 qualified, licensed clinicians with a wealth of experience that spans age and disease continuums, including serious mental illness, serious emotional disturbances, and SUD. BH CMs have personal front-line experience working with Institutions for Mental Disease (IMDs), State hospitals, inpatient psychiatric units, psychiatric residential treatment facilities, substance use facilities, and a wide array of outpatient community mental health resources. This first-hand experience enables our CMs to meet members where they are physically, emotionally, and socially.

Our BH clinicians are fully integrated members of our Care Management team, managing each member's care and services through a holistic, person-centered approach. Our integrated team includes a Nebraska-licensed, board-certified psychiatrist, Dr. Martin Wetzel, who is our BH Clinical Director, along with a team of licensed nurses, licensed BH professionals, and peer supports — all cross trained in PH, behavioral health, and trauma-informed care.

We assign team members with expertise in BH as dedicated points of contact for local EDs to address transition planning, resource needs, appropriate utilization, and other emerging issues for members with BH and SUD presenting at an ED. Through these relationships, we can coordinate care across the continuum of BH services and make sure authorizations are in place to support the facility and the member with transitions to appropriate care settings. In addition, the BH case management team receives a weekly report of all members missing an anti-psychotic and/or SUD Medication-Assisted Treatment (MAT). Local BH Outreach Care Specialists call each of these members to problem solve barriers to receiving medication and offer case management services.

STAR Program. The STAR program was designed for members experiencing SUD. Our BH Case Managers reach out to members who have had ED visits for opioid and alcohol use disorders. We engage members in care coordination and review their benefits to assist them in understanding the services available to them. Based on the needs identified by the member and the supports they desire; we coordinate and refer members to SUD treatment and referrals for MAT and other SUD levels of service. We also want to assure that members are aware of the choices available to them, so they do not have to rely on using emergency services for treatment. We review this with them along with reward programs and VAS available through our care management program.

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Incorporation of Best Practices for Behavioral Health and Mental Health

Within our BH program, members are at the center of their health and health supports. Our team builds and supports customized approaches to treatment, recognizing that there are many pathways to recovery, resiliency, and wellness. We help achieve desired outcomes, such as increased community tenure and prevention or enhanced management of physical and co-occurring mental health disorders, by empowering members to be active and assisting participants in their care. We offer members the tools, education, and resources they need to make healthy choices so that they can achieve overall health.

Our care management program and interventions are rooted in the principles and standards of leading, evidence-based organizations that include NCQA, CMSA's Standards of Practice for Case Management, and the Certification Guide to the CCM Examination, Commission for Case Manager Certification. Our approach promotes the use of evidence-based guidelines as we support members in managing their total health care needs, including BH. Examples of our sources for those guidelines include Healthwise Knowledge Base and nationally recognized organizations such as the American Society of Addiction Medicine, American Diabetes Association, and the American Heart Association. Additionally, our care management program works in collaboration and in consultation with internal resources and disciplines, such as physicians, BH professionals, social workers, pharmacists, dietitians, health educators, and others.

We use State and federal guidelines, nationally recognized and evidence-based criteria, best practices, and other decision-making tools to inform our decision-making processes:

- MCG Care Guidelines®, including nationally recognized, evidence-based clinical guidelines that support care coordination across the continuum of care.
- Healthy Blue clinical guidelines are internally developed based on national Medicaid guidelines and clinical tools for inpatient, outpatient, and BH UM reviews. Our licensed BH clinicians (licensed mental health counselors, licensed clinical addiction counselors, licensed clinical social workers) use the results from tools completed by PH and BH providers to support clinical decision-making. For example, tools can include the Level of Care Utilization System (LOCUS) for psychiatric and addiction services, Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS) scale, and Child and Adolescent Service Intensity Instrument (CASII).
- American Society of Addiction Medicine provides nationally recognized, evidence-based BH clinical guidelines for the treatment of SUD, including opioid use disorder.

While best practices and clinical criteria help inform our decision-making, so that members receive the most appropriate care and services, we also recognize there are always unique, person-centered circumstances that factor into each member's needs. We use

best practices and clinical criteria in tandem with each individual member's needs and preferences, an assessment of the availability of services within the local delivery system, and the treating provider's request. We also consider community-based supports and services to make sure we do not duplicate services.

Member Engagement in Self-management Strategies

To influence member behavior to access health care resources, to adopt healthier lifestyles, and encourage members to self-manage their care, we support members using engagement strategies that begin when the member enrolls with Healthy Blue and continues with our ongoing outreach and engagement activities and direct support through population health and care management activities. When members enroll, we engage them with a welcome call and welcome packet, to make sure members and families understand their benefits and the available programs and services, how to access services, who to contact when they need help, and how to complete a Health Risk Screening and Health Risk Assessment. Our engagement strategies continue throughout a member's relationship with Healthy Blue.

We communicate with members in meaningful ways, including traditional mail, in-person, by telephone, and digitally through our innovative Sydney Health digital engagement platform, text, email, and social media. Our member messaging includes information about covered benefits, our provider network and programs, prevalent health conditions, treatment protocols, and the importance of preventive care. Our communications promote healthy living activities, support members in managing their conditions, promote available Healthy Rewards incentives and enhanced services, and help close gaps in care by encouraging member and family participation. We offer members many opportunities to identify and express their health and social needs with every interaction, including through initial and continual needs assessments, gathering information from providers, and mining demographic and claims data for potential risk based on members' race, ethnicity, and geographic location. This information helps us prioritize additional outreach and engagement strategies to help members quickly connect to needed services and supports. We align our engagement strategies according to the member's level of need.

Healthy Blue Uses Technology to Help Engage Members

Healthy Blue donated $100,000 to the University of Nebraska at Kearney's Rural Measures project to help expand broadband access in Nebraska. Our CEO, Dr. Robert Rhodes, noted, "This donation will provide our rural communities with resources to stay connected, promote health and wellness, and enable emotional and social support. Healthy Blue continues to adopt a digital-first approach within the local community and connect with members when they want and how they want it, putting them at the center. Technology is helping close gaps in care and better support members across the state."

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- **Culturally Competent Outreach.** We consider the member's communication needs and preferences when tailoring our engagement. We conduct culturally tailored member outreach based on detailed analysis showing high social vulnerability scores, poor health outcomes, and existing racial disparities. This outreach provides comprehensive translation services and culturally competent staff use face-to-face outreach and outbound calls to help resolve social risk factors and analyze barriers identified by members.
- **Technology That Connects.** We use technology that helps engage members and promotes healthy behaviors. For example, we offer Sydney Health, a powerful digital ecosystem with personalization at its core, providing a tailored experience to each member based on artificial intelligence and machine learning. The more you use Sydney, the more it will learn your preferences, resulting in smarter recommendations about your health care needs. You can ask questions via chat, use the menus, or have Sydney help you navigate. It is flexible, to cater to our diverse membership and personalizes each member's experience, including tools and resources customized to the member's health history and interests as well as checklists and questions to ask health care providers during appointments. In 2020, Sydney won the Mobile Star Shining Star award for Innovative COVID-19 Prevention or Response, demonstrating our effectiveness in health education. With Sydney, our next-generation web and mobile digital health hub, members can seamlessly access and use the Find Care tool to find a provider. Sydney offers easy-to-use care finder tools, clear benefit details, and health improvement programs in one simple, digital solution. Members can access our My Health Dashboard feature through the secure portal or mobile app. Members can identify areas to improve their health and set up action plans to meet and track towards their health goals. Members can choose when and how they obtain information on care pathways.
- **Welcome Rooms.** Healthy Blue offers five Welcome Rooms, located across Nebraska in Kearney, Scottsbluff, Lincoln, Omaha, and Norfolk. Our Welcome Rooms help members access necessary physical, behavioral, and SDOH needs; improve BH outcomes with the opportunity to attend self-help meetings; and increase access to care tied to community resources, supports, education, and employment opportunities. Healthy Blue identifies and focuses on our rural areas, as we have a Register Nurse CM that resides and works in the Scottsbluff Welcome Room. The CM is actively engaged in rural BH needs for the members, as well as helps improve provider access for our members. We also offer digital solutions kiosks in our Welcome Rooms, which provides members easy access to virtual services, social resources, and on-demand interpreter services.
- **Engagement and Outreach According to Risk Tiers.** Through our care management program, one of our primary goals focuses on providing information and education that promotes condition-specific self-care management, enabling members and

their families to successfully use the benefits, services, and options available to meet their individual needs as well as participate with their medical home, Dental Home, specialists, and other care providers as part of effectively managing their health conditions and preventing complications. Our tiered care management activities include chronic condition management education and appointment reminders through in-person and telephonic outreach by CMs and CHWs to close care gaps. Our Care Management teams provide condition-specific web-based coaching, self-management supports, and education to close care gaps such as for perinatal care or EPSDT services. We customize communications on an individual member basis. For example, all members receive wellness reminders and EPSDT communications, while members in case management or DM programs also receive targeted reminders and condition-specific education.

Social Determinants of Health, Including Risk and Protective Factors for Behavioral Health Conditions

Identifying social risk factors is fundamental to how we assess a member's level of risk and how we work with members to support engagement in care. We include SDOH needs in our stratification methodology, which informs our care management outreach and interventions. When a member completes the Health Risk Screener, this information is readily available in our care management system — providing actionable data to our care management team. We gather member-level SDOH information through multiple sources, both on an individual and community level by capturing SDOH through:

- SDOH screeners and health needs assessments
- Z-code submissions via claims for all members, including new members
- Predictive models, incorporating individual- and community-level SDOH data
- Risk stratification tools that allow us to pinpoint the SDOH and clinical needs of members to identify areas of greatest need

If we identify members needing SDOH supports, we connect them to services using an integrated approach focused on their individualized needs. From preventive to complex care, we help members with referrals to community-based organizations and agencies such as Special Supplemental Nutrition Program for WIC, using warm handoffs wherever possible. Our employees receive specialized SDOH training including housing, education, employment, food, and interpersonal violence topics. Care management staff receive training on how to assist members with connecting to community resources. We meet members where they are — in their homes, institutional settings, community centers, and shelters — and we work with community-based organizations and our trusted providers to locate and engage members in their health care, including connecting them to SDOH resources. Some members are difficult to reach through conventional phone, web, and mail outreach methods and others require multiple contacts to engage with our programs. Our strategies include local, boots-on-the-ground engagement by our CMs, Peer Support Specialist, as well as the engagement of pharmacies, providers, facilities, and the use of technology and data resources.

Specialized Staff and Initiatives that Help Address SDOH

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Our care management services are available to members at all levels of risk to connect them to appropriate providers and community-based services, as needed. We address each member's individual social needs, based on their assessed level of risk. [redacted]

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Value-added Services

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Identification and Tracking of Members

Healthy Blue brings a robust infrastructure that includes technology, tools, and operational processes to proactively identify members with health events and SDOH needs that can place them at increased risk. In addition to the data analytics and predictive modeling tools we use to identify members (described previously in this section), we update care plans monthly and subsequently review the updated care plan with the member. Besides our standard monthly update, other instigators for update include results from integrated rounds, change in health status of the member, or whether the member specifically requests an update. We allow flexibility in the timing of updates to nimbly respond and coordinate member's needs expediently. Through this continuous reassessment process, changing member needs are identified so that we can move and match them to the appropriate level of service. In addition, members may move between stratified levels of care groups over time as their needs change; therefore, we identify changes in member conditions through continual data mining, the Initial Health Risk Screening, Comprehensive Health Risk Assessment, and reassessment processes, and feedback from members and families, providers, and other stakeholders across the system. Events that may escalate a member's risk status and level of service include new diagnoses, a change in the ability to perform Activities of Daily Living (ADLs) and IADLs, a hospital admission or unexpected facility placement, a significant change in caregiver status (such as a serious illness), or homelessness or inadequate housing, which may necessitate a reassessment and an alternate plan for a member.

As part of our risk stratification models, we conduct ongoing continuous case findings to identify updates in members' risk scores resulting from changes in their condition or history. We produce predictive model reports monthly based on a rolling 12 months of data (for example, diagnoses, inpatient admissions, emergency service visits, expenditures, and demographic information). We alert Case Managers to changes in member risk scores through the Health Intech system that may suggest the need for escalation of care coordination level of service. Another opportunity for reassessments occurs when the Initial Health Risk Screening is repeated annually or due to change in health status. Additionally, any member or provider can request a reassessment at any time.

To support fully integrated and comprehensive identification and tracking, our staff are supported by the technology and tools that allow us to view and access all member needs in one location. For example, our care management system contains member care plans, Health Risk Screenings, assessments, care management notes, relevant pharmacy and provider data, demographic history, and phone numbers (extracted from claims). The system is accessible to the Care Management team and UM Clinicians. Regulated data is available to providers through our secure Availity provider tool to facilitate member care coordination and referrals to community resources. Member utilization data, such as claims history, authorizations, immunization records, lab results, pharmacy data, and care and chronic condition management data are readily available in an organized format, delivering a holistic picture of each individual's service utilization, care plan, and gaps in care to the appropriate people.

As shown in Figure V.L.51-5, our system provides a comprehensive view of the member, thereby facilitating the coordination of needs across the continuum of care. The system displays real-time information that includes all demographic data currently on file and available clinic data. Claims, utilization, pharmacy, care gaps, and diagnosis data is displayed in an easily accessible way. Members and providers have access to this information through the member and provider web portals.

Case Studies

Our person-centered, holistic approach to meeting the needs of Nebraskans centers on improving health outcomes and increasing health equity for all members, especially those with high risk, such as the members in the following case studies. While our approach takes into consideration every member's individual health care needs, the case studies we provide highlight our ability to meet the needs of members with high, complex, or Special Health Care Needs that benefit from intensive interventions.

Weaving together powerful data analytics, local provider and stakeholder engagement and collaboration, cross-system coordination, and individualized interventions, our Care Management team guides our approach, making sure everything we do supports members, families, communities, and our State partners to improve health outcomes, regardless of where members live. By engaging partners in care, we build on the strengths of each other, improving the health of Nebraska's communities, tailoring programs and services to address community differences (urban, rural, frontier), while also meeting each member's unique needs to make sure that no member is left behind.

As an incumbent, we have included Nebraska examples along with an affiliate example with similar populations and landscape to demonstrate how our care management program helps us meet the needs of Nebraskans and our ability to leverage the expertise of affiliates who serve similar programs across the country. This includes establishing priorities, strategies, and innovations for meeting the needs of members across ages, conditions, racial, and personal/familial, SDOH, and community differences. To make sure we protect the identities of members and families, we used fictional names in the case studies provided.

Case Study 1: Olivia in Nebraska — Making Sure Every Baby Has a Healthy Start

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Case Study Two: Mason in Nebraska — Assuring Safe and Successful Transitions for All Members

[redacted]

Case Study Three: Michael in Missouri — Keeping Families Together

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Healthy Blue has a comprehensive approach for identifying members in need of care management services. We use State-provided member data, Health Risk Screening (HRS) and Health Risk Assessment (HRA) data, and predictive modeling to identify members who may benefit from care management and take a "no wrong door" approach to accepting referrals to care management from members, providers, and a wide range of internal and external sources. Healthy Blue offers a range of care management services to members across four levels of intensity, ranging from prevention and wellness to complex case management. The HRS and HRA processes, combined with predictive methodologies and tools, are critical to aligning care management services to each member's needs.

Process for Providing Health Risk Screening Upon Enrollment

The HRS is a critical opportunity for members to tell us about their needs, how we can best support them, and it helps us identify who may benefit from interventions within our care management continuum. It builds our understanding of each member's current health status, what they hope to improve, the protective factors they have in place, existing barriers, their immediate as well as ongoing physical or behavioral health concerns, exposure to adverse childhood experiences, and SDOH needs. The HRS also assesses for potential gaps in care, self-perceived health status, future goals, and needs for culturally or linguistically appropriate services. Samples of our HRA's are provided in Attachment V.L.52-1.

Offering Multiple Initial Screening Options

HEALTH EQUITY

We make completing the HRS as easy as possible through a multi-modal approach that provides members flexibility based on their preference and schedule. We encourage all members, parents, and caregivers to complete the HRS form electronically on the member website within 90 calendar days of the effective date of the member's enrollment. Members can also complete the HRS through our mobile app. We include the link to the HRS in key member communications, including the member website and written member materials, such as our welcome packet. If requested, we also provide a version of the HRS that members may submit through the mail. In addition to components described previously, initial outreach includes a combination of mediums including text, phone, and outreach by our Outreach Care Specialists. Reports are run monthly which provide a list of members who are within the first 90 days of enrollment and have not yet completed the HRS. Outreach Care Specialists reach out to those members by phone to complete the screening. The same process occurs for members as they approach their yearly HRS screening. Reminders about HRS completion are sent monthly to members who have an outstanding screen to complete.

Providing Screening Reminders and Support

In addition to the modalities described previously, many members benefit from extra reminders or assistance to complete the HRS. We deliver this assistance in a variety of ways, focusing on meeting members where they are. We provide culturally and linguistically sensitive support to members who need assistance completing the HRS due to language barriers, difficulty reading, or for members who are blind or deaf. We offer written supports to members in multiple formats, producing materials in Spanish and offering translation to a member's primary language. We arrange no-cost oral interpretation services for members and caregivers. Staff have access to interpreters who are trained and competent in health care terminology for translation to more than 230 languages. During welcome calls, we assist members who have difficulty reading the HRS by conducting the HRS verbally over the phone and providing information in image-based formats that assist with comprehension. For members who are blind or have vision challenges, we make the HRS available in large print and braille and provide auditory translation as needed. For members who are deaf or who have hearing challenges, we communicate via Telecommunications Relay Services (TDD/TTY services and 7-1-1) and use our website chat function. We can also arrange in-person American Sign Language (ASL) interpretation to assist members if needed.

Validating Member Information to Maximize Contacts

We use information received from the State when contacting the member, including alternative contact information from a member's providers or pharmacy to make sure we have identified all possible contact numbers. With each member contact, we proactively validate addresses, phone numbers, and ask for their preferred method of contact, recording this information in the member's personal health record maintained in our Health Intech platform. Whenever a member, parent, or caregiver contacts Healthy Blue, employees in all departments check the member's personal health record to identify those who have not completed the HRS and offer to help complete it while engaged with them.

Making Subsequent Attempts to Conduct Initial Screenings

If we are unable to reach members through our initial contacts, we escalate our outreach efforts. We extend our outreach to Saturdays; use a more engaging call script, adding more conversational language that encourages a friendly interaction; and make outbound calls every 15 days until the member completes the HRS or reaches the 90th day of enrollment. In addition, through our Continuous Case Finding process, we continue periodic outreach beyond 90 days, leveraging members' visits to providers or the ED, a prescription refill and, when applicable, make a referral to a Case Manager. Our Outreach Team will go door-to-door and invite members to complete the initial screening while with the member, and our Member Advocates engage with members during outreach events and community activities to check members' HRS completion.

Algorithms and Methodologies to Identify Members Potentially Eligible for Care Management

We have developed a suite of analytics tools to support early identification of members who may benefit from care management. Our risk stratification process blends rigorous and well-honed predictive modeling tools with a thorough analysis of diverse sets of demographics; claims data; health information exchange (HIE) data; ADT and electronic health record (EHR) data; data available from screenings and assessments; and information shared by members, their families, providers, external case managers, and others providing services and support to members. Additionally, we use industry standard predictive modeling to inform our stratification process to leverage algorithms that identify various types of high- or emerging risk populations and include readmission risk assessment surveys (RAS), an Emerging Risk Model (ERM), and low-intensity ER (LIER) utilization risk among others. Member-specific information is refreshed monthly through our Continuous Case Finding process, using updated data sources, including updated claims, ED data, and UM service authorizations. We augment results of the predictive modeling by findings that include the HRS, OB Screener, Waiver Wait Lists, and the clinical judgment of the Case Manager. Other predictive modeling tools generate risk scores for

subpopulations to further identify the risk levels of members, prioritize outreach and assessment, and determine the scope, level, intensity, and frequency of intervention needed. Our predictive modeling tools include:

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Likelihood of Inpatient Admission (LIPA). Predicts likelihood of an inpatient admission within 60 days.

Low-Intensity Emergency Room Tool. Predicts the likelihood of ED visit for low-intensity conditions within the next three months. Members with a high LIER score are segmented according to their needs and identified for appropriate interventions, such as outreach by a Community Health Worker (CHW) or health education reminders.

ED Triage Tool. Synthesizes member data and assigns risk scores to indicate the likelihood of ED visits for ambulatory care sensitive conditions.

STORK Score. Assesses for high-risk pregnancy outcomes or NICU admission based on results of the OB Screener. Members who are identified as potentially pregnant are contacted to complete an OB Screener. The member's answers to specific questions on the screener generates a STORK score, which equates to the member's likelihood of having a baby who will go to the NICU. Depending on the member's STORK score, the member is placed in one of four risk groups: Low, Medium, High, or Urgent.

As part of our risk stratification models, we conduct ongoing continuous case findings to identify updates in members' risk scores resulting from changes in their condition or history. We produce predictive model reports monthly based on a rolling 12 months of data (for example, diagnoses, inpatient admissions, emergency service visits, expenditures, and demographic information). We alert Case Managers to changes in member risk scores through the Health Intech platform that may suggest the need for escalation of care management level of service. Another opportunity for reassessments occurs when the initial health screening is repeated annually or due to change in health status. Additionally, a member or provider may request a reassessment at any time.

Process for Conducting Health Risk Assessments for Members Potentially Eligible for Care Management

Our Case Managers complete the HRA for members identified as potentially eligible for care management through the initial HRS process within the first 90 days. We employ a whole person approach that recognizes each member's risk is affected by more than the diagnosis. We consider acuity level, self-management skills, health care system navigation skills, natural supports (personal relationships such as family, caregivers, and close friends), unmet social needs, geographic location, and more to identify the appropriate level of support needed. Clinicians, including Case Managers, may change a member's stratification level based on additional information received during the assessment, as well as from discussion with our Chief Medical Officer, BH Clinical Director, and team rounds. Using their clinical judgment, Case Managers view member risk trends over time and use other analytic tools, such as underutilization reports, to identify and prioritize member, parent, and caregiver outreach. For example, we welcome feedback from community organizations or system partners who are close to our members and have insight into our members from their own assessment processes. Case Managers identify and assess members based on clinical criteria and indicators such as significant unmet SDOH needs; inpatient and outpatient transitions; physical health, BH, dental, and pharmacy claims data; lack of preventive care; incident reports (suicide attempt, overdose); opioid use patterns; as well as internal and external referrals.

The results of the initial screening form the basis for initial care coordination stratification and drive the completion of the HRA. A member of the Care Management team completes the assessment with the member or family as applicable within 150 days of member enrollment. A Case Manager reviews the findings from the completed assessment and may determine additional assessments are needed to fully identify the member's needs and service level. When additional assessments are needed, the Care Management team conducts specialized, evidence-based assessment modules as applicable to the member's needs. These include an OB assessment, pediatric assessment, behavioral health assessment, and a PTSD screening. Our BH assessment collects information on the member's strengths, housing and community living status, family status, history of and current behavioral health treatment, legal issues, suicidal ideation/homicidal ideation, tobacco use, substance use, prior hospitalizations and ED visits, and diagnoses and onset dates.

Our HRA template includes the following elements and a hierarchy with branching logic that probes more than 20 potential clinical areas to identify a member's risk factors.

- An assessment of the member's:
  - Health status, including issues specific to identified health conditions and associated comorbidities. Includes the member's self-reported health status and event or diagnosis that led to the member's identification for care coordination
  - Functional status related to Activities of Daily Living (ADLs), including bathing, eating, transferring, dressing, toileting, and continence
  - BH status, including cognitive functioning (the ability to communicate needs, understand instructions, and process information about their illness or condition); developmental level; and BH and SUDs
  - SDOH needs that may affect health, functioning, and quality of life outcomes, and risks that may affect the member's ability to adhere to their care plan (such as housing, finance, and food security)
  - Life planning activities and issues such as advance directives, living wills, and health care powers of attorney
- Documentation of the member's clinical and treatment history, including disease onset; key events such as acute phases; inpatient stays, treatment plan, current medication dosages, and schedules, past medications, and therapies or procedures that address the health condition
- Evaluation of:
  - Cultural and linguistic needs, preferences, or limitations, including language/communication barriers; language spoken at home; ability to read/speak/write/understand English; and religious or social beliefs that may influence health care decisions
  - Visual and hearing needs, preferences, or limitations, assessing and accounting for any difficulties that may affect communicating with the member

  - Resources, such as family involvement in and decision-making about the care plan and adequacy of caregiver/support for the member during the initial member evaluation
  - Available member benefits, including any carved-out services and other pertinent information regarding benefits
  - Member's access to and connection with community and natural resources
  - Medication safety, including knowledge, adherence, frequency, dosage, and the need for medication reconciliation, including prescription and over the counter/herbal medications
  - Member's self-management capabilities and willingness to change
  - Member safety concerns or issues, including social support and environmental issues
  - Care coordination needs, including support for transitions of care and other transitions that may affect the member's health
  - Nutritional status
- Identification of barriers to a member meeting goals or complying with the care plan, including language or literacy level, lack of understanding of condition/treatment plan, motivation, cultural/spiritual beliefs, visual/hearing impairment, financial/insurance issues, psychological impairment, and lack of access to transportation

If the clinician identifies an immediate safety concern while speaking with the member, parent, or caregiver, they follow our safety protocol. If the emergency appears to be non-life threatening, they strongly advise the member and their family to contact their PCP. If the emergency appears to be life threatening (the member is a danger to themselves or others), they keep the member on the line, determine if the member is alone, and attempt to engage the help of anyone with the member if possible. If the member is alone or refuses help, they alert another member of the Care Management team to contact 911. They remain on the line until emergency services arrive and confirm they are meeting the member's needs.

If the clinician determines a member has urgent unmet needs, they alert a CHW, who will reach out to the member telephonically, and when needed in-person, to assist in identifying and connecting the member to services and supports. They work with the clinician to address the need for additional services or referrals to providers.

The HRA is in our Health Intech system. The clinician completes each component of the assessment and clearly documents their findings for each area of assessment. They identify any areas that are not applicable to that member at that time and document why. Health Intech automatically date-stamps and identifies the user's name each time the HRA is modified. At all times during assessment, the clinician maintains the confidentiality of member information in accordance with our privacy policies and applicable laws and regulations.

Following completion of the assessment, and based on the clinician's judgment, we enroll the member into the appropriate level of service, which may differ from their initial risk stratification level. The Case Manager may place a member in a higher service level based on the review of all available information but does not place a member in a lower service level. The results of the assessment form the basis for the development of a patient-centered care plan, support level of care decisions, and form a baseline for outcomes measurement.

"No Wrong Door" Approach to Care Management Referrals

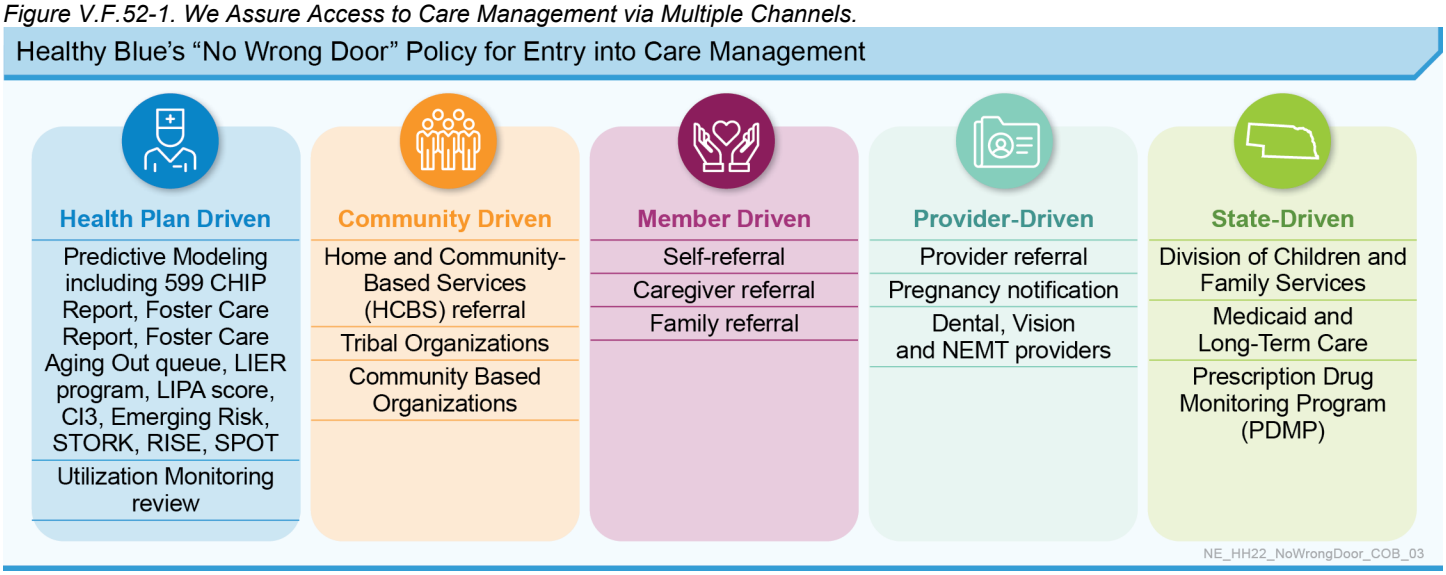
We take a "no wrong door" approach to accepting referrals from members, providers, and a wide range of internal and external sources, as shown in Figure V.F.52-1. Access to care management is not only through data analysis and stratification. Our proactive approach guarantees access to the appropriate level of service through a broad range of referral sources, including:

- **Self-referrals.** Members, as well as their families/caregivers, can refer themselves for care management by contacting the Member Services Line or working with any Healthy Blue team member to seek help with services or clinical concerns. Members can also self-refer by contacting the dedicated Care Management Nebraska email inbox. This information is available on the member portal and member handbook.
- **Member Interactions with Healthy Blue Outreach Personnel.** All Healthy Blue staff who interact with members are trained to recognize the need for referral. CHWs, Peer Support Specialists, Outreach Care Specialists, Grievance/Appeals Representatives, 24-hour Nurse Helpline Nurses, and 24-hour BH service line staff are examples of the types of employees who work in the communities frequently that help refer members for care management assessment.
- **Network Providers.** Network providers are educated on how to refer members to Healthy Blue care management. Provider Experience Consultants engage directly with providers to educate on how and when to refer members, including a secure email inbox, a fax form located on the provider portal, or a one-touch referral function in the secure provider portal Availity, which is integrated with Health Intech.
- **Discharge Planning Staff.** Healthy Blue Care Management staff coordinating discharge planning have real-time access to CyncHealth and can use this to proactively refer members for care management. Referrals are also received during integrated rounds while members are still in acute settings so there is no delay in discharge.
- **State Staff.** We receive referrals from State personnel, such as from the Chief Medical Officer and DHHS Executive Medical Officer. Each State agency or program has its own dedicated point of contact at Healthy Blue, streamlining case management referrals.
- **Community-based Organizations (CBOs).** Organizations that serve a wide range of member needs and populations work with our Community Engagement team to refer members to case management, such as newly pregnant or homeless members.
- [redacted]

In addition to the methods described previously, members who submit the Medically Complex Self-Referral form or the Homelessness Identification form get assigned to care management for outreach. Per contractual requirements, the Medication Therapy Management program will also have a process in place to refer high-need patients to care and/or case management.

Using a wide range of data, we stratify members into tiered risk levels for outreach and engagement according to their service needs, including care coordination, transitional case management, case management, and complex case management. Upon engagement, a dedicated Care Manager works side-by-side in coordination with the multi-disciplinary care team to help members navigate the complicated care delivery system when they are most in need of services, improving care coordination through an individualized, integrated care plan.

Figure V.F.52-1. We Assure Access to Care Management via Multiple Channels.



No. 53

Healthy Blue's patient-centered program recognizes member risk levels are influenced by a wide array of factors — diagnosis, treatment history, family and other supports, and unmet social determinants of health (SDOH). Our stratification process blends rigorous and well-honed predictive modeling tools with information gleaned from people who are closest to our Heritage Health members, such as family members, caregivers, CHWs, providers, and community organizations. With a whole person approach to stratification, Healthy Blue identifies and initiates the level of service that is right for each member. For example, members engaged in the foster care system are likely affected by trauma, which may not be captured in predictive modeling, but influences their individual risk level. The predictive model may indicate a lower risk level for an older adult with comorbid medical conditions, but significant unmet social needs would escalate their risk level. By endorsing a flexible and patient-centered approach to stratification, Healthy Blue initiates the level of service that will result in the best outcomes for each member with defined goals, as summarized in Table V.L.53-1.

Table V.L.53-1. Healthy Blue's Goals and Plan for Achieving Goals by Risk Level.

Risk Stratification Level	Care Management Goals	How the Goal Is Achieved
Level 1: Prevention & Wellness	Empower members to achieve optimal health through education focused on healthy living, prevention, and wellness	Delivering on-demand education, programming, and tools, including value-added services, online tools, preventive screening reminders, and comprehensive member service assistance
Level 2: Disease Management	Building member self-management and self-advocacy skills	Coaching to enhance self-management, preventive care reminders, and self-service tools
Level 3: Case Management	Guiding the member to care and services by establishing a path to achieving self-identified and care plan goals	Remote monitoring of chronic conditions, care coordination (provider and community resources), targeted interventions for high ER utilization, and assistance navigating the health care system and care transitions between settings
Level 4: Complex Case Management	Coordinate and integrate care for members with the most complex needs	Enhanced care coordination with key providers, peer supports, and clinical programs

Our care management teams are fully integrated to promote appropriate member engagement aimed at informing stratification, improved outcomes, and a whole person approach. Nurses and BH clinicians are available across all business hours. Members enrolled in Disease Management, case management, and complex case management are assigned a Care or Case Manager, respectively, whose expertise is most relevant for them, and every Care and Case Manager receives support from their multidisciplinary colleagues. In addition, our CHWs work with members in the community to enhance care coordination program engagement and address identified needs. Multidisciplinary case rounding assures we adopt a whole health approach to helping members identify and achieve their goals.

Services Available to Members in All Risk Levels

In addition to stratifying members based on disease states or conditions, Healthy Blue's model reflects a whole person approach. Under our model, every member's risk is affected by more than the condition with which they are diagnosed. We consider acuity level, self-management skills, health care system navigation skills, natural supports (that is, personal relationships such as family, including foster families, caregivers, and close friends), SDOH barriers, geographic location, and more to identify the appropriate level of service and interventions. All members, regardless of risk stratification level, receive the following services:

Welcome Calls. In addition to the initial prevention promotion and wellness welcome calls (completed within 10 days of sending a member's welcome packet), our Care Managers and Medical Management Specialists outreach to new members within three months of enrollment. These calls are focused on additional education to members on Healthy Rewards and other prevention and wellness benefits and programs and include a set of preventive care/wellness questions.

[redacted]

Risk Level 1 (Prevention/Wellness)

Our prevention and early intervention strategies for our members in Risk Level 1 are anchored in our health equity and population health infrastructure that uses technology and self-service solutions to help members achieve and maintain optimal health through education focused on healthy living.

Objectives of these services include:

- Educating members about health risks and mitigation strategies
- Influencing healthy behaviors to decrease need for more intensive interventions in the future
- Promoting health literacy

Services and interventions available to our members stratified in Risk Level 1 are detailed in Figure V.L.53-1:

Figure V.L.53-1. Healthy Blue's Risk Level 1 Services and Interventions Focus on Education and Influencing Healthy Behaviors.

Risk Level 1: Prevention and Wellness Services and Interventions

- Online access to tools and resources that promote healthy behaviors
- Value-added Services
- Coordination of additional services, including enhanced services, community services, and social supports to address unmet social needs
- Community-based support from Community Health Workers
- Customer call line and the Member Services Helpline
- Medication Therapy Management
- Community Resource Link
- 24/7 Nurse Line and BH Crisis Line
- Tobacco and nicotine prevention and cessation programs
- Referrals to community resources and supports
- Assistance to obtain needed care (such as durable medical equipment or testing strips)
- Preventive service reminders, gaps in care alerts, and education
- Healthy lifestyles educational materials (including alternative forms such as braille, recorded materials, or languages other than English or Spanish)
- Peer and integrated case rounds
- Health Education A-Z
- Electronic health record
- Enhanced services
- Office based Diabetic Retinal Eye exams
- Wellness events at Welcome Centers

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Risk Level 2 (Rising Risk/Disease Management)

Our program is a model of care that strives to address members' health needs at all points along the care continuum, including the community setting, by increasing member participation and engagement and targeting interventions. ***Our program incorporates member, family, and provider interventions.*** The DM program manages thirteen conditions, nine of which are NCQA Accredited (indicated by an asterisk in the following list): Alzheimer's/dementia, asthma*, bipolar disorder, chronic obstructive pulmonary disease*, coronary artery disease*, congestive heart failure*, diabetes*, HIV/AIDS, hypertension*, major depressive disorder–adult*, major depressive disorder–child and adolescent*, schizophrenia*, and substance use disorder.

Objectives of these services include:

- Helping members with chronic conditions
- Building self-management skills with support from our Care Coordinators and Health Educators
- Promoting adherence to evidence-based care and services

Services and interventions available to our members stratified in Risk Level 2 are detailed in Figure V.L.53-2:

Figure V.L.53-2. Healthy Blue's Risk Level 2 Services and Interventions Help Support Members with Chronic Conditions and Build Self-Management Skills.

Risk Level 2: Rising Risk and Disease Management Services and Interventions

Member Outreach and Education, Wellness, and Health Promotion

- New Member Welcome Call and Initial Health Needs Screening
- Assignment to Care Manager
- NCQA Accredited Disease Management Programs
  - Asthma
  - Depression (Adult and Adolescent)
  - Chronic Obstructive Pulmonary Disorder
  - Coronary Artery Disease
  - Congestive Heart Failure
  - Diabetes
  - HIV/AIDS
  - Schizophrenia
- Member Services Helpline
- 24/7/365 BH Crisis Line and Nurse Line
- Prenatal My Advocate Program
- New Baby, New Life℠ Pregnancy Supports
- Telehealth Access and Kits
- Pregnancy and Beyond Program
- CommonGround
- Non-NCQA Accredited Disease Management Programs
  - Pregnancy
  - Attention Deficit Hyperactivity Disorder
  - Autism
  - Pervasive Development Disorder
  - Chronic Kidney Disease
  - Hypertension
  - Substance Use Disorder
- Medication Therapy Management Programs
- Health A-Z Education Programs
- Community Resource Link
- Electronic Health Record
- Text Message Health Reminders
- Member Liaison Outreach and Engagement
- Healthy Rewards Program
- 20 Value-added Services
- Tobacco/Nicotine Prevention and Cessation Programs
- Breast Feeding Consultation and Breast Pumps
- Family Planning and Education
- Community Services and SDOH Needs

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An example of an innovative care management strategy available to our members in Risk Level 2 includes:

Telehealth Kits

To maximize the effectiveness of telehealth visits and facilitate more meaningful relationships between members and their virtual providers, we are distributing Telehealth Kits to members with chronic conditions (diabetes, blood pressure, high-risk pregnancy, and asthma). The kits include basic medical devices such as fingertip oxygen sensors, blood pressure monitors, digital thermometers, digital scales, and BMI tape measurers and will help members obtain more accurate readings during virtual sessions. They will also assist members with managing their health conditions — in collaboration with their treating physicians — and reduce health disparities at home. Our Telehealth Kits will promote continuity of care and work to increase rural access by empowering physicians with better insights into their members' medical state during telehealth visits. The member will be able to monitor the diagnostic results from the kits and can share results with their provider to add to the member's medical record — something that could not otherwise be obtained via telehealth visits.

Risk Level 3 (Case Management)

Within Risk Level 3, services focus on assisting the member in navigating the health care system and care transitions between settings, as well as collaborating with physicians, community resources, and natural supports in implementing their plan of treatment. We support members in optimizing their use benefits to obtain high quality health care across all health care settings. The Care Management team partners with each member to develop care plans focused on the member's self-identified needs and gaps in care within the core principles of patient-centered care. The Case Manager utilizes skills in motivational interviewing to encourage the member to create and achieve specific and attainable goals toward improved health behaviors. Health care goals are coordinated across all settings through evidence-based best practice models. Care plans integrate members' physical, behavioral health, and social needs, which include multidisciplinary internal program clinicians and external providers of care. Members needing catastrophic case management are stratified into Risk Level 4, Complex Case Management, detailed later in this section.

Objectives of Risk Level 3 services include:

- Perform the activities of assessment, planning, facilitation, and support throughout the continuum of care, and provide evidence-based, patient-centered care planning that is consistent with recognized standards of case management practice and accreditation requirements
- Provide information and education to members and their families that promote condition-specific self-care management to facilitate their ability to manage their care and improve their health
- Promote medication safety by assessing the member's knowledge and adherence and performing medication reconciliation
- Provide timely interventions that increase the effectiveness and efficiency of the care/services provided to the member and promote achievement of the measurable goals in the case management plan
- Educate and involve the member and family in the coordination of appropriate services that effectively use benefits and/or other health care resources
- Provide members with connection and coordination of community resources to address needs including social determinants of health throughout the care management process but especially when benefits end and the member still needs care
- Assure continuity and continued access to care to assist members when their current provider leaves the network while the member is in an active course of treatment
- Address social determinants of health barriers, gaps in care, and care transition issues to mitigate or prevent potential readmission to hospital or facility-based care

Services and interventions available to our members stratified in Risk Level 3 are detailed in Figure V.L.53-3:

Figure V.L.53-3. Healthy Blue's Level 3 Services and Interventions Focus on Navigating the Health Care System and Care Transitions.

Risk Level 3: Case Management Services and Interventions

- Comprehensive Health Risk Assessments
- Short-term Case Management and Care Planning as Needed
- Person-centered Care Plan and Multidisciplinary Team
- Integrated Biweekly Case Rounds with Interdisciplinary Expertise
- Targeted Community Paramedic Home Visits for Unmet Resource or Social Needs
- Targeted Priority Population Condition Specific Outreach and Education
- Increased Interventions as Risks Are Identified
- Care Transitions Interventions (CTI)®
- Condition Specific Case Management Programs Including Behavioral Health (BH), Fostering Connections, Substance Use Disorder (SUD)
- ER Diversion Program
- Concierge Care: Personalized condition management solution specialized support, integrated remote monitoring, coaching and provider engagement
- Remote Monitoring
- Emerging Risk Model Care Coordination

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Additional innovative care management strategies available to our members in Risk Level 3 include:

Care Transitions Interventions (CTI)®

CTI is a 30-day post-discharge program for those over 18 and leverages an evidence-based model developed by Dr. Eric Coleman. A predictive model identifies members for assignment to a Transitions Coach (Registered Nurse trained and/or certified in CTI). The Transitions Coach then works to engage the member in CTI with the strategic goal of coordinating care to reduce preventable 30-day hospital readmissions, produce cost of care savings, close gaps in care, and improve HEDIS/STAR ratings. This program has been proven to reduce gaps in care and readmission rates while also reducing costs. CTI focuses on those members at highest risk for a rapid readmission, thus promptly engaging them to assess and address red flags and allow for real-time oversight. CTI supports members by engaging them in care through coordination and partnerships with both inpatient and outpatient providers, which results in reduced readmission rates and improved quality of care.

The CTI process incorporates member identification through proprietary predictive models, such as Readmission Score (RAS), to improve our ability to focus on our members most likely to be readmitted within 30 days post-discharge. The engagement model is designed to predict the likelihood that a member will engage in a clinical program if they are outreached to. The engagement product score is a weighted number calculated for all members to reflect the engagement likelihood based on their Readmission Predictive Model scores.

Emerging Risk Model (ERM) Care Coordination

The ERM care coordination program focuses on proactively identifying and resolving member needs through coordination of care with the member's medical neighborhood and assisting the member in optimizing utilization and benefits and available resources. The medical neighborhood includes a set of relationships revolving around a patient and their health care needs. Collaborating "neighbors" can include the PCP, specialty providers, case managers, social workers, physical therapists, visiting nurses, pharmacists, laboratories, and hospitals.

ERM care coordination provides short term coordination of care assistance to member needs and includes, but is not limited to:

- Emerging risk (cohorts/clusters as identified by predictive model)
- Referral and coordination to medical neighborhood and resources
- Reducing barriers to accessing care
- Assisting members with benefits and community resources
- Closing gaps in care
- Educating on conditions/medications/self-identified needs
- Accessing transportation
- Assisting members with transition of care to a higher level with no interruption for member continuity if needed

Risk Level 4 (Complex Case Management)

The fourth level of our care management program serves members identified with complex care needs. Through this care, we strive to deliver optimal value for members by objectively improving health, function, safety, and member satisfaction, empowering members to self-manage through education and support, and identifying and closing barriers to care to improve member well-being. For example, identified catastrophic and specialized member needs are managed within the level of CCM. The Behavioral Health team locally manages these members and may conduct face-to-face visits for assessment and assistance with resources. The team includes eight licensed clinicians located across the state to best serve our members when a face-to-face visit is needed. Our program model is centered around whole person integrated care.

Our CCM program objectives are to:

- Perform the activities of assessment, planning, facilitation, support throughout the continuum of care, and provide evidence-based, member-centric care planning that is consistent with recognized standards of case management practice and accreditation requirements
- Empower members and their families by providing information and education that promote condition specific self-care management to facilitate member behavior change
- Promote medication safety by assessing the member's knowledge and adherence and performing medication reconciliation
- Provide timely interventions that increase the effectiveness and efficiency of the care/services provided to the member and promote achievement of the measurable goals in the case management plan
- Educate and involve the member and family in the coordination of appropriate services that effectively use benefits and/or other health care resources
- Provide members with connection and coordination of community resources to address needs including social determinants of health throughout the case management process but especially when benefits end and the member still needs care
- Assure continuity and continued access to care to assist members when their current provider leaves the network while the member is in an active course of treatment
- Address social determinants of health needs, gaps in care, and care transition issues to mitigate or prevent potential readmission
- Improve member and provider satisfaction

Our CCM content is based on current evidence-based guidelines referred to as clinical practice guidelines (CPGs), derived from nationally recognized sources such as: American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Obstetrics and Gynecologists, American Diabetes Association, American Heart Association, National Institutes of Mental Health, Substance Abuse and Mental Health Services Administration (SAMHSA), HIV Medicine Association of the Infectious Diseases Society of America, Eighth Joint National Committee (JNC 8), and the National Alliance for Tobacco Cessation.

Services and interventions available to our members stratified in Risk Level 4 are detailed in Figure V.L.53-4.

Figure V.L.53-4. Healthy Blue's Risk Level 4 Services and Interventions Focus on Members with Complex Care Needs.

Risk Level 4: Complex Case Management Services and Interventions

- Complex Case Management, Integrated Rounds, and Multidisciplinary Team (MDT)
- Children with Special Health Care Needs
- Post Discharge Management (PDM) Program
- Pomelo Care: Rural High Risk Pregnancy Management program
- Palliative Care Program and Advanced Illness Case Management (Aspire)

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Additional innovative care management strategies available to our members in Risk Level 4 include:

Aspire

Aspire palliative care provides an extra layer of support for patients with serious illnesses. Palliative care is specialized medical care that focuses on providing relief from pain and other symptoms of a serious disease, no matter the diagnosis or stage of disease. The goal is to improve the quality of life for the member and their families. Our Care Management team works closely with the Aspire care teams to make sure members' needs are met. The Aspire care team assures that services are delivered in collaboration with the member's PCP and specialist physicians. Members can enter palliative care upon being referred from their PCP or specialty provider from the ambulatory, inpatient, or skilled nursing facility. Palliative care can occur in any of these care settings including in the member's home environment.

[redacted]

[redacted]

Integrated Rounds

We have implemented a range of integrated rounds to facilitate ongoing co-management, communication, and collaboration on facilitating member engagement in the most appropriate care. Our specialized case rounds offer the opportunity for clinical staff to consult with our Chief Medical Officer and BH Clinical Director regarding members with specialized, complex, comorbid, or co-occurring conditions. This collaborative care management, UM (with LTSS expertise and knowledge), and clinical approach provides the team an opportunity to develop innovative strategies to include in the member's care plan and determine the best path to support the member, while also removing barriers to care. Scheduled integrated rounds occur weekly and provide an opportunity to escalate unresolved issues or unmet member needs for resolution and solution. In addition to weekly rounds, the integrated care team meets on an ad hoc basis to address urgent member needs that are best addressed by a multi-specialty team approach. Hence, integrated care coordination is part of what we do every day for members.

During integrated rounds we also focus on members with the highest trending readmissions who have returned to inpatient and help prepare supports for members and their caregivers before they discharge. We also work with the member to identify any barriers to care and work with the member to close gaps, including facilitating appointments and coordinating transportation services to support post-discharge treatment compliance. A UM Clinician uses admission, discharge, and transfer (ADT) data to identify hospitalized members and notifies the Care Manager, who engages the member, participates in daily rounds, and facilitates appropriate discharge planning.

Innovative Care Management Strategies

Admission, Discharge, and Transfer Program

Our ADT program is focused on patients who are discharged from the hospital against medical advice. This program focuses on care management by giving providers the opportunity to reach out to members for evaluation and management or transitional care management visits. In one example, a 62-year-old member with congestive heart failure was admitted for worsening signs of heart failure about three weeks after a prior admission. The member was discharged against medical advice. Our team offered the member an appointment within the next week to address high-complexity medical decision-making. During a follow-up call through the ADT program, the member revealed a new treatment regimen. ADT program nurses talked with the member about how the new drug will help him manage his condition, helping the member to understand his treatment plan better. At a visit one month after discharge from the second hospitalization, the member reported significantly improved function.

Behavioral Health

The Behavioral Health Case Management team receives a weekly report of all members who missed an anti-psychotic and/or substance use disorder medication-assisted treatment. Local behavioral health Outreach Care Specialists call each of these members to resolve barriers to receiving medication and offer case management services. All 1,200 members diagnosed with a substance use disorder (SUD) were reached out to and offered case management in 2021. Every member admitted to a behavioral health facility are reached out to by a licensed clinician to offer support and case management, along with discharge planning assistance, daily. Members at an inpatient level of psychiatric care in the network's largest facilities are personally contacted by the plan before discharge to optimize access to a BH follow-up appointment.

Programs to Target Enrolled Members Underusing, Overusing, and/or Abusing Services

Throughout each level of our care management program, we identify members underusing, overusing, and/or abusing services. Through the health screening and risk assessment processes, some members may have some indicators of health risk, but do not necessarily meet the criteria for case management. Because we want to make sure any member with an important health risk is identified, we use risk stratification tools, emerging risk models, and information gleaned from clinical rounds. These processes bring to light members that are underusing, overusing, and/or abusing services so that we can create the appropriate patient-centered coordination efforts to assist them. For example, members who consistently lack timely completed preventive care and immunizations or who do not complete follow-up care, whether for a newly identified or chronic condition, are identified by flags in the Health Intech and in the Member 360°$_{SM}$ platforms. We subsequently develop individualized outreach focused on preventive care, provide self-management education, and connect them back to their PCP. We identify the appropriate level and type of member engagement and may deploy our additional resources for those members who could benefit from additional help.

Overutilization of services is identified through routine monthly HEDIS data runs on specific utilization metrics and PQI reviews for readmission and emergency department (ED) utilization issues. We improve outcomes through outreach, education, and connecting members with alternative care options such as their PCP or other treating provider. Additionally, we reach out to providers to discuss how practice relates to what we see in the data. We also work collaboratively with acute and post-acute facilities to improve processes to reduce length of stay, where appropriate, readmission, and streamline the discharge process. Health Intech supports our review of individual-level data (for example, demographics, care management assessments, and referrals) and population-level data to identify member-, provider-, or group-specific; geographic or service-specific; and diagnosis-specific utilization. Additionally, our Restricted Services team identifies members through data review that may meet criteria for restricted services (lock in). Members are identified for review based on opioid overutilization or utilizing multiple pharmacies and prescribers to obtain multiple controlled substances within a 90-day period. Members are presented to the team with representation from care management, pharmacy, and Medical Directors to not just review for restricted services, but also identify any additional services to offer members and their providers to help improve their health outcomes.

No. 54

Providing Connections to Community Resources

We take an integrated, patient-centered approach to health care that includes identifying and addressing the unmet social needs of members and their communities. Our approach provides an operational foundation and structured framework to support member health and ensure they connect to community resources where people live, work, and play. [redacted]

[redacted]

Identifying Member Needs

Identifying social risk factors is fundamental to how we assess a member's level of risk and work with members to support engagement in care. [redacted]

Our Care Management Team Connects Members to Resources and Support. Our employees receive specialized SDOH training including housing, education, employment, food, and interpersonal violence topics. [redacted]

Encouraging Providers to Identify and Address Social Support Needs. Providers play a critical role in helping identify and address members' SDOH needs, and we continually work with providers to understand SDOH service gaps and opportunities. [redacted]

[redacted]

Supporting Members to Gain Access to Community Resources

[redacted]

Healthy Blue Resources and Innovations

[redacted]

resources and increase community capacity.

[redacted]

No. 55

Challenges and Associated Healthy Blue Mitigation Strategies for Care and Case Management Delivery to Dual-eligible Individuals

Our parent company and Healthy Blue routinely manage the coordination of Medicare and Medicaid services and Medicare cost sharing for dual-eligible members across the country and in Nebraska, respectively. Our parent company has coordinated Medicare and Medicaid benefits for our Medicaid members since 1992. Nationwide, our organization serves more than 340,000 Medicaid dual-eligible members, with Healthy Blue currently serving 8,472 in Nebraska. Because of the high prevalence of chronic conditions and the care coordination needs among multiple providers and payers, we recognize that dual-eligible members have complex needs and unique challenges for those providing care and case management for these individuals.

Our parent company has extensive experience delivering Medicare Advantage DSNP programs in states that embrace that integrated care approach. Collaboration and delivery of these programs has enhanced our ability to anticipate and proactively handle challenges that dual-eligible members pose, regardless of whether they are in one of our DSNP programs. Specific to our operating experience, we have outlined challenges in accessing Medicaid care and case management and our approach to mitigating those challenges to make sure that our members have access and the advantage of Care Case Managers and anticipate the HIDE DSNP program will mitigate many of the challenges outlined next.

Challenge 1: Timely Identification of Members with Dual-eligible Coverage and Where Medicare Coverage Is Coming From

Mitigation Approach 1: Proactive Identification of Dual-eligible Members. We identify dual-eligible members through the State 834 enrollment file. As we work with individuals and caregivers, our member outreach and clinical staff identify and document the specific Medicare carrier and whether the member has a Medicare Care Manager (CM). In addition, we regularly perform retrospective review of secondary claims because they are indicators of additional coverage. By reviewing secondary claims, we can further identify dual-eligible individuals and determine from whom they are receiving covered services.

Challenge 2: Duplicate Assessments and Potential for Care Management Information Gaps Tied to Member Engagement Fatigue

Mitigation Approach 2: Establish Complete Member Risk Assessments. Our staff is tasked with establishing a complete member risk assessment for as many members as possible within the first 90 days of enrollment with Healthy Blue, with a special emphasis on dual-eligible members because of their risk and utilization profiles. When we identify a dual-eligible member from an eligibility file or secondary claims source, we task our staff with 1) ascertaining what type, if any, of assessment a member has been exposed to; 2) obtaining any assessment and care plan documents from the member or their Medicare payer; 3) assessing what information is needed to complete a Medicaid risk assessment that helps determine appropriate CM selection; and 4) acquiring missing assessment information to close gaps so that Healthy Blue has a complete baseline picture of a member's conditions, health, and needs.

Our approach minimizes duplication of effort associated with multiple assessments and related member contacts by using any previously collected Medicare payer information, closing any information gaps to make sure that a comprehensive patient-centered care plan is in place, and establishing a collaborative care management framework that features transparency and communication between CMs to assure the best possible health outcomes for the member. Our approach maximizes member engagement by minimizing data collection fatigue. It is our preference and objective to create an integrated care plan whenever possible to avoid confusion and effectively make the entire continuum of benefits available to our members based on individual and unique needs.

Challenge 3: Identification and Connection to the Right Level of Care Management and Coordination Support

Mitigation Approach 3: Provide Effective, Up-front Care Management Staff Assignment. Assignments should be tied to a member's unique risk and need profile:

- ***Risk stratification of all Medicaid members*** readily determined through screenings and assessments, claims, Medicare payer case management input, and prior authorized services analysis in conjunction with a comprehensive review of the member's medical, service, and support needs and identifies an appropriate CM who reviews and authorizes appropriate services.
- ***Our CMs have extensive knowledge and experience working with dual-eligible individuals*** to provide seamless care and promote optimal utilization of services via services and support navigation, as needed. They also have specialized experience areas should the need arise related to things such as behavioral health, care transitions, and community service support.

Regardless of who manages the member's Medicare coverage, our collaborative approach features a single point of contact through an assigned CM as a key flexible contributor to our success and member satisfaction.

Challenge 4: Timely Member Engagement and Participation

Mitigation Approach 4: Development of a Member-specific Communication Plan. This plan and approach are a part of every Healthy Blue care plan. Our CMs work with members to establish a communication calendar that sets when and how a member would to communicate with us. We augment this member-driven/selected engagement approach by offering multiple access points to the CM and their care plan (direct on the web, via member services, etc.); providing information in multiple formats, such as audio and visual oriented to triggering engagement as needed; and connection support through access to mobile phones as needed. By focusing on member-defined communication, we avoid contact fatigue and related disengagement.

Challenge 5: Medicare Payer Engagement Level Is Not Equal; Support for Medicare Fee-for-Service Different From MCO Service Support

Mitigation Approach 5: Care Alignment and Support for Dual-eligible Individuals Complement Payer Support. We align care management and coordination support for dual-eligible members to complement payer support:

- ***Members enrolled through Medicare fee-for-service (FFS)*** will require additional assistance because the Medicare FFS program does not provide a CM or single point of contact for care coordination. In the absence of a PCP under the Medicare FFS program, a Healthy Blue CM identifies the member's PCP or one or more treating physicians; works with the providers to obtain additional necessary information; and explains the community-based services available, the process for authorization of Medicaid covered services, and the details of Healthy Blue care coordination.

- ***Our CMs for dual-eligible members enrolled in another MCO*** coordinate services in full compliance with the Medicare Improvements for Patients and Providers Act. For members who are receiving services from a Medicare MCO, our CM works directly with the MCO Case Manager to discuss identified needs for the dual-eligible member.

Our CMs who work with dual-eligible members receive continual training to assure their comprehensive understanding of Medicare and Medicaid requirements and coverage. Consequently, our CMs can analyze Medicare and Medicaid data to identify gaps in care and collaborate with members and their PCPs or other providers to close these care gaps, regardless of whether Medicare or Medicaid pays for the care or service. Staff will also respond to HEDIS® alerts in our care coordination and management.

Challenge 6: Payer Benefit Determination Denies Coverage under Medicare

Mitigation Approach 6: CM Outreach and Coordination with the Medicare Payer. The CM completes outreach when coverage is denied.

When a service a provider or member requests through the Medicare plan is denied or results in an adverse decision, our CMs working in collaboration with the Medicare Case Manager will determine whether coverage and related benefits are available under Medicaid. This coordination may include reviewing the request under the Medicaid contract to determine coverage in a timely manner. Note that not all denials result in the need to perform a review under Medicaid:

- In instances where a Medicaid benefit is available and a contracted Medicaid provider must provide the benefit, our Healthy Blue CM will connect the member to the appropriate provider. In addition to connections to providers, CMs will facilitate the connection of members to community-based organizations that provide wraparound support for noncovered services to Medicaid members.
- In instances where there is no Medicaid coverage or community service outlets available to a member, our CMs assist members with appeals navigation and engage the Utilization Management (UM) team on the member's behalf to provide a denial review, where appropriate.

Challenge 7: Discharge and Transition Planning and Service Continuity

Mitigation Approach 7: When a Dual-eligible Member Is Hospitalized, CMs Actively Monitoring Member Progress Before Discharge. Our effective Care Transitions Intervention program establishes member monitoring and care coordination that includes:

- Working with the Medicare payer discharge committee to make sure that all member needs are known and assigned to Medicare or Medicaid in accordance with Medicare being the primary payer, with our CMs creating any needed discharge reports specific to Medicaid
- Supporting effective benefit and service reconciliations during transitions to make sure that any Medicaid services stop upon admission and restart, if appropriate, upon discharge
- Identifying, engaging, and coordinating any transition services and support a member may need, such as home and community-based services or Non-Emergency Transportation to post-discharge medical appointments. We engage with providers to manage other care transitions in a similar manner to help provision complementary Medicaid services

Challenge 8: Service Support Coordination for Covered Medicaid Benefits

Mitigation Approach 8: Healthy Blue Emphasizes That Care Coordination Is Not Contingent on the Payer. Rather, it is contingent on the unique needs of a member regardless of the Medicare plan (FFS or Medicare Advantage) the member chooses. Our care management model features the same intensity of care management and coordination; only the operational details differ based on payer type. During the care coordination or UM process, our CM and UM staff will monitor authorization of services to identify the correct payer source and engage it appropriately in each instance. Part of these activities may include:

- Coordination with Medicare and the state as needed
- Working with members to connect with their Medicaid PCPs, if they are different from their Medicare provider, to access covered services through a Healthy Blue contracted provider
- Supporting direct access to Medicaid covered providers that are not covered under Medicare, such as Licensed Mental Health Professionals
- Connection to community service and support providers as dictated by a member's need
- Eliminating any payer confusion specific to Part D versus Part B office visit–delivered injections

No. 56

Healthy Blue Dedicates Resources to Identify and Assist Members Who are Homeless or at Risk of Homelessness

Healthy Blue is committed to addressing and meeting members' whole-person needs, including those associated with homelessness and housing instability which may adversely impact a member's overall health. Rapid identification and engagement of members in care management and case management support is essential to preventing homelessness and meeting the complex needs of members who are chronically homeless. Our strategy includes:

[redacted]

Member Identification

[redacted]

Care and Case Management Outreach and Engagement

Engaging members at risk of or experiencing homelessness is critical in connecting them to services that help them lead healthier lives. Our Care Managers (CMs) review the member's HRS and all other available information, including our risk stratification data, completes additional needed assessments or screenings, and determines the member's initial care management level. They engage chronically homeless members in complex case management.

[redacted]

Development of a Member-Specific Plan. CMs develop a member-specific plan to address the member's housing, housing stability, wraparound services, specialized programs, and other needed supports, which includes a comprehensive, patient-centered care plan for members engaged in complex case management (as described in our response to Question 51). Members may discreetly discuss with the CM any barriers they are facing, receive one-on-one referrals to resources, and discuss their benefits, including requests for Healthy Blue Value-Added Services. [redacted]

Healthy Blue Provides Specialized Training Focused on Meeting the Needs of Members with Housing Instability

[redacted]

[redacted]

Healthy Blue Specialized Supports Promote Access to Housing and Wraparound Services

In addition to referring members to local community resources, we have developed a variety of internal supports and programs aimed at addressing members' housing needs. [redacted]

Strengthening Community Partnerships to Increase Housing Stability

Strengthening our community partnerships with organizations that provide leadership, coordination, or direct services to individuals and families experiencing homelessness improves our ability to serve our members. [redacted]

No. 57

Healthy Blue's Process for Care and Case Management for Members in Foster Care

Healthy Blue offers our members timely access to an extensive network of high-quality primary and specialty care providers who deliver the full array of covered services. As an incumbent MCO serving the State for more than five years, we have a unique understanding of the populations we serve, the services they need, and the providers available to serve them. Together with our affiliated health plans across the nation, we leverage more than 26 years of best practices from coordinating care for more than 117,000 members in similar programs, including foster care, former foster care, adoption assistance, and juvenile justice. To meet the needs of members and families, our comprehensive approach includes tailored processes, specialty services and programs, and on-the-ground staff. Healthy Blue provides patient-centered, trauma-informed care and care management to all members. This care fully integrates physical health and behavioral health (BH) care as well as addresses social determinants of health (SDOH) and pharmacy needs.

Dedicated Care Managers Support Our Foster Children and Adolescents Aging Out of the Foster Care System

[redacted] and we use best-in-class tools to support transition-aged youth (TAY).

[redacted] Their primary focus is on identifying, engaging, and supporting members to improve health outcomes, such as reducing likelihood of facility admission and/or readmission, decreasing preventable emergency department use, eliminating duplicative services, and coordinating fragmented care. Our CMs develop relationships with members and their Division of Children and Family Services (DCFS) case workers, and support assessment, care planning, and coordination processes.

[redacted] Once the child is assessed, we develop a care plan for members whom we identify would benefit from care management. The care plan involves the PCP, and in the case of discharge planning, we convene a multi-disciplinary care team. Our CMs reach out and touch base with their assigned members and their families at least weekly. They also contact providers, the State, other community supports, discharge planners, probation officers, and any other involved parties or resources. We expect our CMs to meet face-to-face with members and their expanded care teams when appropriate.

[redacted]

Healthy Blue's integrated approach embraces all of our members' needs. Our CMs work with members to develop care plans with goals that value self-determination. We conduct weekly integrated rounds with our Care Management teams, medical providers, and BH providers to leverage our resources and partnerships to achieve the best outcomes for our members.

Healthy Blue Processes to Coordinate Services and Supports for Our Members

[redacted] CMs work with the members and their stakeholders to determine risks, needs, and appropriate supports. When children and youth are in foster care, our team includes consultation with the legal guardian to determine appropriate supports according to a child's placement. Whether under the care of kin, foster parents, or their biological family, Healthy Blue's Care Management team has the local community, system, and BH experience to be able to support stability of placement, offer resources to caregivers, identify and resolve gaps in care for frequently transient youth, and promote continuity of care.

Healthy Blue supports our members with an approach that incorporates youth and family input and choice in the health care and service decisions that impact their lives. We also define "family" broadly and recognize it can include family of origin, kinship caregivers, foster parents, or other designated legal guardians. We understand that caring for caregivers is critical to the stability of placements, and this is true for kinship, adoptive, and foster families. That is why our approach includes assessing the needs of the family regarding

SDOH; incorporating respite into care plans as appropriate; providing access to evidence-based services, such as Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy; and offering value-added services (VAS).

Our dedicated CMs review the services youth receive and discuss whether providers will be able to remain with them during and after transition. We also review any additional resources that may be available to support them during and after transition from the foster care system and into adult health care.

[redacted]

We collaborate with multiple organizations that provide services for TAY and will maintain a reference tool to assure that youth aging out of foster care are aware of and can access local resources such as the Fostering Educational Success program and the Connected Youth Initiative (CYI), which includes Project Everlast, Opportunity Passport, and the CYI Support Services Fund.

Our Foster Care Workgroup Supports Care and Case Management

[redacted] We participate in ad hoc meetings to identify and address emergent or urgent needs for individual members as well as issues related to the system of care. Our approach is collaborative as we engage with agencies and organizations to support our members and families.

Transition Planning for Foster Youth Aging Out of the Foster Care System

[redacted]

Charting the LifeCourse

[redacted]

Got Transition

[redacted]

No. 58

Care and Case Management for Members Residing in Assisted Living or Long-Term Care Facility

Healthy Blue's care management program is comprehensive, multi-disciplinary, and patient-centered, designed to proactively address the needs of our members at all levels of need across the continuum of care. We implement a whole person approach to care and case management for all members, described in our response to V.L.51 and V.L.52, including members residing in long-term care (LTC) or nursing facilities (NFs), and members living in community-based assisted living facilities (ALFs). We assign Care Managers (CMs) to specific facilities so they develop close working relationships with the facility staff and have an in-depth understanding of the facility's capabilities. We provide individualized care and case management support to each member that reflects their identified needs and place of residence.

Our Care Management team of licensed masters-level social workers, licensed alcohol and drug counselors, registered nurses, Community Health Workers (CHWs), and Peer Support Specialists work with members, their providers, families, and caregivers to implement care and case management for members residing in an LTC facility or ALF. They are supported by the Utilization Management (UM) team and UM Clinicians who focus on the clinical needs and appropriateness of levels of care and transitions. The Care Management team works collaboratively with the member, facility staff, their PCP, specialists, and others involved in the member's care to monitor and continually review the member's health status. For members residing in ALFs and enrolled in HCBS waivers such as the Aged and Disabled Waiver, their Waiver service coordinator is an integral part of our care-planning process.

Identifying Members in LTC Facilities and Assisted Living Facilities

Healthy Blue identifies members for care and case management based on their risk and complexity — not member setting. Our Care Management team contacts members and, when applicable, their designated representative in LTC facilities and ALFs in person and by phone, based on member preference. We also receive referrals from family members, facility and other providers, and our UM team. During this contact, they introduce Healthy Blue, complete the Health Risk Screening as described in our response to V.L.52, and invite the member to participate in care management. If the member consents, they are assigned to a Care Manager or Case Manager aligned with the facility. If the member declines, the Care Management team continues to follow the member and offers care management support when needed, including when a member is hospitalized, following an ED visit, or during transition from the facility to another level of care or provider.

Care Management Support

Once enrolled in our care management program, our integrated team collaborates to support members' physical health and BH needs. CMs implement our assessment and care-planning process described in our response to V.L.51 and V.L.52. [redacted]

The Healthy Blue CM works with the members to choose who will be part of their interdisciplinary care-planning process and assists the member in driving decisions about their health care. We also determine if we need to set up meetings with DHHS, including with MLTC, family, and providers, to foster a collaborative model of care for the member. Our members in an ALF or LTC facility also benefit from integrated care rounds, which includes our Chief Medical Officer, BH Clinical Director, Case Management Administrator, Behavioral Health Manager, CMs, and other supportive staff.

Healthy Blue Facilitates Safe Transitions

Members experiencing a critical transition, or a change in residential setting, require careful, proactive, and supportive planning that promotes continuity of care and timely access to needed services and supports. As part of our care management approach, Healthy Blue engages with and addresses each person individually to reduce medical and social barriers. We promote personal choice in helping our members, families, and caregivers prepare for transitions before they occur. Our strategies support seamless transitions of care.

[redacted]

Transitioning Members to and from Acute Care. During the authorization and concurrent review processes, the UM team members use the census to help with the transition of care as necessary and review care provided in daily rounds with the plan's Medical Director(s) and other team members. This report is refreshed twice a day to communicate daily admissions as well as after-hours admissions. This communication is especially important as the UM team becomes the initiator for discharge planning, coordinating with the assigned CM. The UM Clinician is responsible for transition of the member to and from acute and post-acute care settings. The UM Clinician communicates daily, or as often as appropriate, with the patient or responsible party, hospital CM department, and the attending physician or care team in charge of the member to determine all transition of care needs and ensure the activities are seamless. The UM Clinician continues to facilitate transitions from the inpatient setting to an LTC facility, ALF, or other setting and communicates with member/guardian/caregiver on next steps, lets them know to expect a call from a discharge planner to conduct discharge assessment and to ensure all identified needs are met, including transition, if appropriate, to long-term care or ALF settings.

Our Integrated UM team closely monitors facility waitlists to help support our members with care setting options to meet their short and long-term needs as appropriate. Through continued stay reviews and clinical rounds, we continue to assess the member's progress. If the member is not improving, we work in conjunction with the facility staff (such as their social worker or discharge planner), to educate the member/guardian/caregiver on all options regarding the member's care and the most appropriate setting. We coordinate closely with the member and the facility when the member can transition safely home or if the member requires a longer-term facility stay.

[redacted]

For members residing in a LTC facility, we work with Nebraska's Pre-Admission Screening and Resident Review (PASRR) providers to review their screening of the facility's ability to meet the member's needs and that the care plan reflects these needs. This occur when members transition from an inpatient stay to a LTC facility. We have dedicated CMs that collaborate with the providers to ensure PASRRs are completed and support discharge to an appropriate level of care. If member meets NF Level of Care, they may choose to receive their care in an LTC facility. We recognize this as a choice and assure safe discharges to community settings, demonstrating our commitment to member choice and most integrated setting. Our CMs assure safe discharges including ordering of all durable medical equipment (DME) and availability when needed. For those members returning to a community setting that does not offer prepared meals, [redacted]

Transitioning Members to a More Integrated or Preferred Setting. Healthy Blue focuses on member preference and safety in supporting the residential setting choice of our members. While ALFs are a community-based residence, our CMs make sure our members residing in ALFs are happy with their living arrangement — that they have choice, are treated with respect, and are integrated in the community to the extent they desire. If the member is not satisfied with their current housing arrangement, our CMs participate with their Waiver service coordinator to assist in transitioning them to another community setting. In this context, the role of the Healthy Blue CM depends on whether the member has a service coordinator.

When a member who is either a short- or long-term resident of an LTC facility expresses interest in moving home or to another more integrated setting, our CM coordinates with the medical and BH providers and the therapy department (physical, speech, occupational therapy) to help determine readiness to transition. As part of their care plan, we assist the member in finding a new PCP and help schedule initial follow-up care after discharge from the facility. We also connect members with state agencies that manage waiver programs and help them access transition services such as Money Follows the Person. For example, as part of their care plan, a member experiencing severe mental illness may choose to transition from an LTC facility to supportive housing structured with intensive support services. This type of transition may include supports such as Assertive Community Treatment (ACT) that provides community-based mental health care to allow them to live in the community, attend health care appointments, and manage mental health symptoms. [redacted]

When issues arise such as a facility closure or a desire to move to a preferred setting, we advocate on the member's behalf and problem solve to resolve any issues that may impact their health and health care services. We leverage our relationships with providers and state officials when needed to help our members live safely and comfortably in the most integrated and/or preferred setting.

Assuring Continuity of Care for LTC Members

In 2021, when several Nebraska LTC facilities closed, our Care Management team contacted the members and the facilities to help support safe and positive transitions to other facilities. **We had daily contact with the facilities to help set up transfers and approvals to new facilities, and to help support members with transitions of care.** We made sure that there was continuity of care, covering primary and specialty care, scheduled procedures, and medication refills. We worked with staff at the facilities to review care plans and ensure everything was addressed without delay.

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No. 59

Healthy Blue's Process for Care and Case Management for Tribal Members

Healthy Blue's approach to care and case management promotes whole-person health through a collaborative, member-centric population health model that integrates physical health, behavioral health (BH), and social determinants of health (SDOH). We support members with a range of specific, tailored care management interventions focused on helping members achieve improved health outcomes. Our physical health and BH Care Managers (CMs) and Case Managers, Outreach Care Specialists, and Peer Support Specialists, with assistance from our Tribal Network Liaison, Gelisha Jeffers, coordinate members' service and support needs with Tribal social workers and Indian Health Services (IHS) providers. They help Tribal members, and members otherwise eligible for care through the IHS, to access services and supports that address their identified needs, are culturally relevant, and of their choosing. To enhance our outreach and engagement for all members, we will be deploying Community Health Workers (CHWs) and through MedAware, dispatch community paramedics to help connect members to health care services and social supports.

For members at all risk levels, our Care Management team coordinates the member's services and supports with their IHS provider, tribally operated facility/program, or urban Indian clinic (I/T/U), and other agencies or programs from which the member receives services or supports. Members identified for engagement in specific care management programs (including Disease Management, OB care management, discharge management, or complex case management), have an assigned licensed clinical social worker or RN CM who implements care management interventions specific to the member's identified needs. Our CMs include four BH CMs with experience working with youth and adult American Indian (AI) members in Nebraska and one CM who has worked on the Pine Ridge reservation.

Informing and Engaging American Indian Members in Care and Case Management

When Healthy Blue becomes aware that a newly enrolled member is AI, including from the AI indicator in the enrollment file, and is receiving care through the IHS, our Care Management team contacts the member and completes a Health Risk Screening (HRS). They describe our care and case management supports as applicable to the member's identified needs (and described in our response to Section V.E.51) and invite them to take part. We also accept referrals for care management at any time from members, their families, providers, and anyone else involved in supporting the member.

The CM reviews the results of the member's HRS and all available claims and other data, and for members with complex needs, completes a Health Risk Assessment (HRA) in-person or by phone, based on member preference. They may complete additional screenings and assessments as needed and use this information to develop the most appropriate care plan. The CM works with the member's IHS provider to coordinate the member's treatment and promote access to care, linking members with providers, our telehealth options (described in our response to Section V.E.21), local resources, and our value-added services (VAS), [redacted] On an ongoing basis, our CMs identify a member's gaps in care and link members to providers and appropriate SDOH supports.

Promoting Care and Case Management Services for AI Members

Gelisha participates in regular (at least quarterly) and ad hoc meetings with the leadership of each Tribal organization to discuss our referral process for care management, available community supports, and any service needs they identify among Tribal members. In addition, she participates in state Tribal calls and during one of these calls, identified a need for suicide prevention and smoking cessation service. We provided information on how to access our smoking cessation benefit and information on suicide prevention, which is available in our member materials and obtained through the Member Services Call Center, BH service line, 24-hour Nurse Helpline, and Care Management team.

Gelisha also advocates for AI members with our Care Management staff by identifying ways to improve access to care and support services, especially those that are culturally relevant and easily accessible to Tribal members. To enhance our support for AI members, beginning July 1, 2022, our Care Management team will meet with Gelisha in weekly huddles focused on resolving specific needs among our AI members, promoting communication with their providers, removing specific barriers to care, and supporting linking members to resources to address their specific SDOH, physical health, and BH needs.

Healthy Blue's Commitment to Culturally Appropriate Services

Healthy Blue understands the importance of providing culturally appropriate services. Our Tribal Member Advocate, Teresa Zahren, has specialized training and experience working with AI members. Most recently, she participated in the National American Indian/Alaska Native Behavioral Health Conference sponsored by the National Indian Health Board, and Wakanyeja, A Conference on American Indian Behavioral Health sponsored by the University of Nebraska Center for Great Plains Studies. We currently perform an annual Culturally and Linguistically Appropriate Services survey and provide relevant trainings for providers and staff on identified issues. We also assure access to culturally competent services by monitoring and expanding the network of Tribal providers.

[redacted]

No. 60

Coordinated Service Planning, Service Delivery, and Post-discharge Care

Our holistic approach to care management supports members' integrated physical, behavioral health (BH), and SDOH needs across the care continuum. Our Care Management team, working closely with our Utilization Management (UM) and Provider Experience teams, promotes coordinated service planning and access to services and supports to meet the needs of members as they transition among providers, settings, and programs.

Our Care Management team is the primary point of contact for members in transition from one level of care to another. Our licensed masters-level clinician and registered nurse Care Managers (CMs), who are hired from communities where our members live, are located throughout the state and understand local nuances and resources, including in rural and frontier areas. Our CMs are available to members in remote areas in-person when needed, either at one of our Welcome Rooms or the member's place of residence (including in a hospital or residential facility). For example, a Healthy Blue BH CM can meet a member at our Scottsbluff Welcome Room upon request and is assisting members in this rural area with access to and coordination of care. In addition, we will be hiring Community Health Workers (CHWs) from local communities, including in rural areas, to help reach and engage members in their care and coordinate local community resources.

We assign members not already engaged with a CM and who are admitted to hospitals or residential care to a facility-designated CM for the duration of their stay and for post-discharge follow-up. Beginning with implementation of the new contract period, we plan to use this same approach with Nebraska State psychiatric hospitals and the crisis centers through facility assigned CMs. In addition, we assign UM Clinicians to specific residential and inpatient providers and facilities throughout Nebraska to help build personal relationships and facilitate exchange of clinical information. [redacted]

Access to timely and convenient care is critical to avoiding readmissions. In addition to maintaining a fully complaint provider network, we offer members telehealth and video-conferencing options summarized in Table V.L.60-1.

[redacted]

Through the combination of our care and case management interventions, access to care initiatives, and focused Performance Improvement Projects (PIPs), we achieved improvements in a range of measures that included a focus on proactive follow-up to prevent readmissions and other high-cost care. [redacted]

Proactive Identification and Discharge Planning for All Members

Rapid and proactive identification of members' transitions in care helps us anticipate members' needs and connect them with the care and supports services they need upon discharge. The UM team reviews our hospital census data daily, including State psychiatric hospital census data, through a dashboard that provides real-time data in chronological order. From this data, we identify newly and currently admitted members as well as prior authorization requests, including requests for residential levels of care. The UM team refers newly admitted members to the to the Care Management team for initiation of discharge planning.

[redacted]

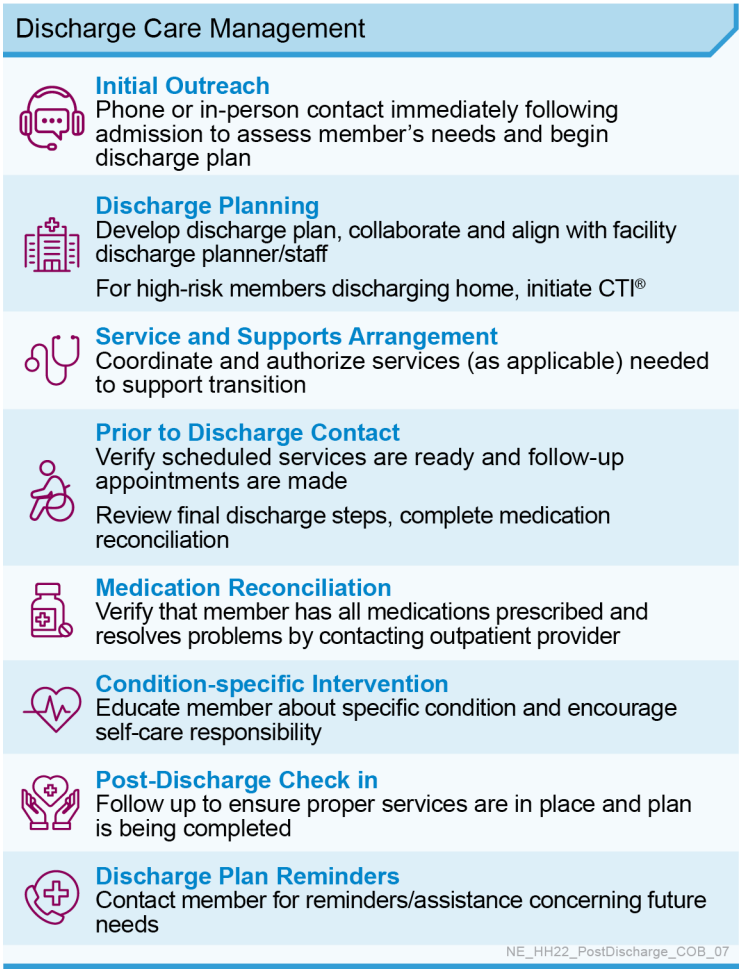
[redacted]

Our CMs and UM Clinicians collaborate with the member, family or caregiver, and hospital discharge planners to develop and implement a discharge plan that includes member education. They arrange services and supports needed to support discharge home or to the next level of care, completing medication reconciliation, making follow-up calls after discharge to assure members are receiving needed services and supports, and connecting members to specialized services (such as in-home care) designed to prevent readmission.

The CM helps the member identify realistic short- and long-term care goals, the services and supports needed to reach self-identified goals, and the location and frequency of the services. They identify and coordinate any special in-home care and supports (such as nursing care and DME) and any needed referrals and coordination to access high-quality, in-network secondary levels of care, such as acute inpatient rehabilitation, long-term acute care hospitals, skilled nursing facilities, and a wide range of outpatient BH services. They also secure an outpatient BH follow-up appointment within seven days of discharge and follow-up to assure completion, or help the member reschedule the appointment.

During each member contact, the CM assesses the member's status, reviews transition progress, and the remaining activities required before discharge. The member's CM documents the transition plan in the member's care plan. They continue enhanced follow-up with weekly check-ins for at least 30 days post-discharge.

Figure V.L.60-1. Evidence-based Interventions Promote Safe Transition.



[redacted]

Focus on Quality – Performance Improvement Projects. In 2018, we developed a Follow-up After Emergency Department Visit with a Behavioral Health Diagnosis PIP. This PIP focused on improving seven- and 30-day follow-up after an ED visit for SUD and mental illness with the goal of improved health outcomes and stabilization of BH conditions by linking members with appropriate and needed care. Our PIP implemented interventions such as improving current data streams through integrating CyncHealth information, promoting the use of our BH service line to members and providers and contacting members identified as having a PIP-related ED visit to offer care management services and follow-up appointment scheduling assistance. [redacted] Our ***Plan All-Cause Readmission PIP*** addresses members who are at high risk for a readmission within 30 days of discharge from the hospital. We focus on the multi-disciplinary needs of members who are high-risk, with BH needs, and health disparities to improve the hospital readmission rate among our population. This PIP will focus on the Plan All-Cause Readmission measure of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge (for Medicaid, ages 18 to 64). [redacted]

Service Planning

Because transitions of care represent a time of heightened risk if not proactively and comprehensively managed, our Care Management, UM, and Provider Relations teams work together to explore the range of service and support options that remove members' barriers to discharge. Using a multi-disciplinary approach, they collaborate to identify specialized services, providers, programs, and community resources that together will meet the member's total needs, assure no gaps in care, and reduce the risk of readmission and probability of needing a higher level of care. For members who are discharged home with identified home health needs, the UM team sends a referral to the Care Management team. The Care Management team identifies and addresses the member's needs and gaps in care, home safety, and availability of family and/or community support. They evaluate, educate, and support members and their families during their transition between care settings. CMs check in with the member post-discharge to confirm home health and other services are in place and satisfactory to the member, resolve any concerns, and reinforce the member's care plan.

We share information with facility staff in accordance with the provider's policies and procedures and as permitted under federal and State laws governing access to member data. Our care management system, Health Intech, provides role-based access to member assessments, care plans, care management notes, relevant pharmacy and provider data, demographic history, and phone numbers (extracted from claims). The system is accessible to the Care Management team and UM Clinicians. Regulated data is available to providers through our secure Availity provider tool to facilitate member care coordination and referrals to community resources. Member utilization data, such as claims history, authorizations, immunization records, lab results, pharmacy data, and care and chronic condition management data, are readily available in an organized format, delivering a holistic picture of each individual's service utilization, care plan, and gaps in care to the appropriate people. Our experienced CMs recognize, however, that our most powerful communication is one-to-one communication with providers, pharmacists, therapists, community support workers, and ED diversion staff. CMs contact providers directly to obtain a letter of necessity or authorization for services needed by the member (such as personal care services, private duty nursing, or home health services), to inform the provider of a member's new diagnosis, help a member refill a prescription, or consult on a member who has become hard to reach.

Members Who Need Additional Support During Transition. We hold internal, integrated rounds several times a week to discuss discharge planning and resources and to identify approaches to promoting effective transitions for members with frequent readmissions or whose discharge is delayed due to lack of specific resources, such as specific placements, housing, or services. Our rounds include our Chief Medical Officer (CMO), BH Clinical Director, other Clinical Directors, Clinical Managers, and other support staff. In addition, Healthy Blue's Medical Directors are available to our Care Management team, PCPs, specialist providers, and other facility staff for consultation.

Patient-centered Meetings. Regardless of whether a member has physical, behavioral, or obstetrical (OB) health needs, we realize that some situations benefit from an elevated team approach to planning through interdisciplinary patient-centered meetings. Our CMs lead these meetings, but all relevant clinical area staff are involved. We invite and encourage members, their families, and caregivers to participate in these discussions so we hear the voice of the member and can all work together to plan for optimal transitions, support, and outcomes.

REAL STORIES

A **Winnebago Tribe member** recently suffered an assault that resulted in a traumatic brain injury and admission to inpatient care. The Tribal case management team was having difficulty identifying a rehabilitation setting for this member and contacted the Healthy Blue Care Management team for assistance.

In the interim, the member was discharged home and while at home was found to be both a danger to herself and others. DHHS-Adult Protective Services intervened to help support the family during this time, while we worked with the tribal CM team and took the lead in identifying a suitable placement for this member.

Because of the member's complex needs, we engaged our BH and Utilization Management teams in twice weekly touch base conferences and met with our CMO, a Provider Network representative, Care Management leadership, Regional Director of Healthcare Management, and Care Managers. We identified a suitable facility that could meet the member's needs and arranged long distance transportation to the facility. As arrangements proceeded, we provided daily updates to DHHS and the Tribal CM team, while they in turn provided updates to the member and family. This member is now safe in a rehabilitation setting where she is receiving proper care and treatment.

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Provider Collaboration. [redacted]

Coordinating with Other Programs and Funding Streams. We cooperate with other entities and programs, including with other State agencies and their contractors, tribes, and other community providers from whom the member may receive services, to make sure their transition plan and service array is comprehensive and inclusive of all available services and supports without duplication. We collaborate with the Nebraska Association of Behavioral Health Organizations (NABHO), Division of Behavioral Health (DBH) and their funded programs, and the six Regional Behavioral Health Authorities to identify critical service needs. For example, we learned that access to intensive community services such as home-based mental health services was being interrupted by our existing prior authorization frequency. We immediately increased initial authorization for up to a year to promote continued community support for members and stable community living.

Our field-based CMs in areas across the state participate in community-based committees or other stakeholder engagement opportunities to gather additional information on member needs and available resources. We have developed and maintain an integrated Provider Advisory Committee with regular and formal interaction and feedback opportunities. This includes representation of from DBH-funded programs on our Provider and Member Advisory Committees, as well as other quality committees.

Service Delivery

We assure post-discharge service authorizations and member outreach are in place prior to a member's discharge from the hospital or residential setting and make post-discharge calls for at least the first 30 days following discharge to confirm delivery of DME, initiation of home health services, and coordination of outpatient appointments. To promote successful transition and avoid readmissions or the need for higher levels of care, our CMs identify and connect members to additional, valuable services and supports offered by Healthy Blue and by CBOs. Table V.L.60-2 summarizes several examples.

[redacted]

Provider Incentives that Promote Discharge Follow-up

Our provider value-based purchasing (VBP) programs promote delivery of high-quality care. We align our VBP program measures and targets to advance the Nebraska DHHS Quality Strategy for Heritage Health and the Dental Benefit Program, and goals for improved quality, access, and outcomes. Table V.L.60-3 summarizes three VBPs that include a focus on improving post-discharge care.

[redacted]

Care Management for Youth Discharged from Residential Care

[redacted] he CM contacts the facility and youth's family/foster family/guardian to assess the youth's needs and completes initial and follow-up health screenings immediately following admission and periodically throughout the youth's stay to identify and assure their physical and BH conditions are treated. CMs assess the youth's health status, including condition-specific issues, co-morbidities, clinical history, medications, activities of daily living such as eating, bathing, and mobility, mental health status, cognitive functions, and psychosocial factors. The CM engages parents, foster parents, DHHS workers, juvenile probation officers, and providers as applicable to the youth's needs in an integrated discharge plan to assure the member's total needs are addressed and to avoid gaps in care. They check in periodically to assist with any issues that arise as the discharge plan is implemented.

[redacted]

Monitoring Post-discharge Care in Remote Areas

We monitor the post-discharge care of members in remote areas to assure members receive the services and supports needed to avoid readmission or higher levels of care and to identify trends that may indicate a need for quality improvement activities. Our annual evaluation of quality of care includes evaluation of continuity of care as members transition across settings. We also investigate all complaints and grievances and identify trends, including access to care and quality of care concerns, which may indicate a need for additional solutions. Our monitoring includes:

- Post-discharge check-in calls from the Care Management team for at least the first 30 days after discharge to assess the adequacy of post-discharge services and supports.
- Periodic UM review of service authorizations that assess the member's progress in meeting their treatment plan or care plan goals. If a member is not progressing, the UM team engages the Care Management team in reassessing the member's needs and identifying needed adjustments. Specific needs may also be reviewed in internal rounds with discussion by our broader clinical team, including Medical Directors.
- Review of specific quality measures, including HEDIS measures (such as BH and SUD measures for follow-up after hospitalization for alcohol or drug dependence) and utilization measures (ED and inpatient use, residential placements, lengths of stay, and admission diagnoses).

No. 61

We use a broad range of data and evidence-based decision support tools to leverage and integrate technology to improve care for our members. Upon this foundation of data, we establish the priorities that drive targeted interventions, implemented by our specialized teams to lift our members' overall health and well-being. While we work to drive improvement in all HEDIS® measures, our overarching strategic priorities focus on key Medicaid program goals, namely: promoting primary and preventive care, improving members' chronic conditions, coordinating health and social services, using technology to ease administrative effort, and assuring all services are delivered through a health equity lens. Our parent company continues to expand our available suite of innovative health intelligence tools. With such comprehensive information, we can isolate population vulnerabilities through a lens of race, ethnicity, and cultural preferences to identify disparities, providing truly actionable information. We are continuously re-evaluating the population needs, re-identifying priorities, re-establishing measurable goals, redesigning programs and interventions, and re-measuring outcomes. We use this comprehensive data intelligence to develop targeted programs, create the most relevant enhanced benefits and services, and invest intentionally at the local level to build capacity and sustainability aligned with the priorities of our membership. For example, our collection and analysis of member and provider outcomes includes disparities data, care gaps, social determinants of health data, claims analysis, EPSDT services management, well-baby and well-child assessments, immunization services, and grievances and appeals.

Decreasing Readmissions

These tools have driven improved outcomes over the last two years (2019–2021), including **decreases in avoidable ED visits (-15.36%), inpatient admissions (-19.85%), and readmissions (-60.1%).**

NE_HH22_AvoidableERVisits_COB_02

Leveraging Technology and Data to Improve Care

Our approach is informed by data at both the population and member level, integrating and transforming data from multiple sources into actionable information that provides in-depth insight into all aspects of population health:

- At the population level, we capture and review multiple data elements from comprehensive health assessments, and quantitative and qualitative data from primary and secondary sources including demographics, care gaps, and data elements captured via social mapping tools and predictive modeling.
- At the member level, we use data elements including encounter data, utilization management (UM) data, risk scoring, provider referral, member or caregiver self-referral, biopsychosocial status, health equity needs, access to care, living environment, support system, and safety.

Our UM and Care Management teams work collaboratively to identify gaps in care based on review of available utilization data, including the development of other Disease Management programs as necessary. These teams work proactively to identify members who need care management services, such as members who have high utilization of services, including emergency department (ED) and pharmacy as well as gaps in preventive and wellness care, and provide education and refer members to such services as appropriate. Our approach balances multiple data sources and team collaboration to present a comprehensive picture of our members' needs and barriers. We have leveraged this monitoring and oversight of members to develop a suite of specialized reports, such as:

- **Medication-Assisted Treatment (MAT) and Antipsychotic Medication Gap in Prescription Refill Report.** These weekly reports identify members who are late in filling these medications, and triggers calls from our Behavioral Health (BH) team to the identified members to assist with any barriers to filling medications.
- **Gaps in Care Report.** We created this report to show providers/practices the gaps in care for the members they serve and provide insight to focus member outreach. The report includes all quality measures with the percentage that meet thresholds to date for the month.
- **Cash Pay Report.** This information allows us to conduct focused outreach to educate members on their covered benefit and to educate providers on prescribing patterns and poly-drug use. Our goal is to support member engagement with a network MAT provider so that their treatment services are covered.
- **MAT Dashboard.** This dashboard identifies members who are paying for poly-drug use/cash pay for MAT services, so we can focus our outreach and monitor member use.
- **ED Claims Report/Specific BH and Opioid Use Disorder Report.** This suite of BH utilization reports is used for specific provider engagement opportunities for those providers that are high volume. We also use the top utilizer member report for specific outreach, specifically by our Discharge Continuum Liaison Case Managers.
- **Social Risk Factors Report.** Our Care Management teams, including ED and specialty teams, use this report when reaching out to members. We can drill down by risk factor and assist with connecting to community resources. Our member experience team will develop a texting campaign to make sure members are aware of local resources available. This allows us to focus on the entire population and not just those engaged in higher levels of care management programming.

Evidence-based Decision Support Tools

To improve care management for members, we have developed a suite of analytics tools that support early identification of members who may benefit from more intensive levels of support. Table V.L.61-1 outlines the criteria for risk stratification in care management. Our predictive modeling tools include but are not limited to:

- **Proprietary Predictive Models.** Our Chronic Illness Intensity Index (CI^3) tool, based on the Johns Hopkins Predictive Risk Scoring Model, incorporates utilization and claims, demographics, pharmacy claims, lab, diagnosis, assessment, and other member data. CI^3 is the primary component of our predictive modeling system and identification tool used for initial stratification thresholds. Using CI^3, we develop individualized risk profiles and — combined with our other predictive modeling tools — identify members who may benefit from additional interventions.
- **Likelihood of Inpatient Admission (LIPA).** Predicts likelihood of an inpatient admission within 60 days.
- **Low-Intensity Emergency Room (LIER) Tool.** While traditional predictive modeling tools help us identify members with high service use for care management outreach, our tools also predict emerging risk — identifying members for proactive engagement to delay or avert the onset or escalation of symptoms and comorbidities. LIER predicts the likelihood of an ED visit for low-intensity conditions within the next three months. Members with a high LIER score are divided according to their needs and identified for appropriate interventions, such as outreach by a Community Health Worker or health education reminders.

- **ED Triage Tool.** Synthesizes member data and assigns risk scores to indicate the likelihood of ED visits for ambulatory care sensitive conditions.
- **Statistical Obstetrical Risk Score.** Predicts a pregnant woman's probability of delivering an infant that will require the Neonatal Intensive Care Unit based on the OB Risk Screening Tool.
- **Suicide Prevention Outreach Team.** A predictive model to support adults (27 and older), adolescents, and young adults (ages 12–26) who are at high or critical risk for a first or subsequent suicide attempt over the next 12 months. Key predictors include a history of suicidal ideation, substance use, mental health diagnosis, and a history of trauma. When working with minors, we obtain parental consent to work with the youth as well as provide education and support to the family.

Table V.L.61-1. Risk Stratification to Guide Level of Care Management.

Risk Group Stratification	Clinical Criteria	CI³ Risk Score	LIPA Score	Predicted Care Coordination Need	Area of Care Coordination Focus
Risk Group 4 (High Risk)	Most complex with manageable conditions and highest likelihood of imminent admission	≥ 6.79	≥ 32	High	Complex Care Management
Risk Group 3 (High Risk)	High clinical complexity with manageable conditions and high likelihood of imminent admission	≥ 6.79	< 32 and ≥ 11	High	Complex Care Management
Risk Group 2 (Moderate Risk)	Clinically complex with manageable conditions; high predicted future medical costs but low risk of imminent admission	≥ 6.79	< 11	Moderate to high	Disease Management and/or Stabilization Management
Risk Group 1 (Low Risk)	At least one clinically manageable condition; moderate-low risk of high future medical costs	< 6.79	N/A	Low to moderate	Disease Management and/or Stabilization Management
Health Promotion and Wellness Group	No clinically manageable condition	Any	N/A	None	Health Promotion, Quality Management

Monitoring and Adjusting Our Predictive Modeling Tools. Our national health care analytics team monitors all predictive models monthly to verify accuracy. They complete a formal annual assessment for each tool's effectiveness and make revisions following testing and validation, such as verifying our algorithms do not inadvertently perpetuate disparities. For example, a recent review of the ED predictive tool resulted in a change in focus from the number of ED visits in the previous six months to a model that examines low-intensity ED use and considers an array of contributory factors, such as number of primary care and outpatient visits and the member's age. The model was refined through machine learning and is proactive rather than reactive. It identifies members for potential outreach and engagement, guiding level of service determinations for care management.

Identifying Changes in Member Conditions. Healthy Blue identifies changes in member conditions through continual data mining; the initial Health Risk Screening, Health Risk Assessment, and reassessment processes; and feedback from members and families, providers, and other stakeholders across the system. Trigger events that may escalate a member's risk status and level of service include new diagnoses, a change in the ability to perform Activities of Daily Living and Instrumental Activities of Daily Living, a hospital admission or unexpected facility placement, a significant change in caregiver status (such as a serious illness), or homelessness or inadequate housing that may necessitate a reassessment and an alternate plan for a member. As part of our risk stratification process, Healthy Blue conducts ongoing Continuous Case Finding to identify updates in members' risk scores resulting from changes in their condition or history. We produce predictive model reports monthly based on a rolling 12 months of data (for example, diagnoses, inpatient admissions, ED visits, expenditures, and demographic information). We use the Health Intech platform to alert Case Managers to changes in member risk scores that may suggest the need for escalation of level of service.

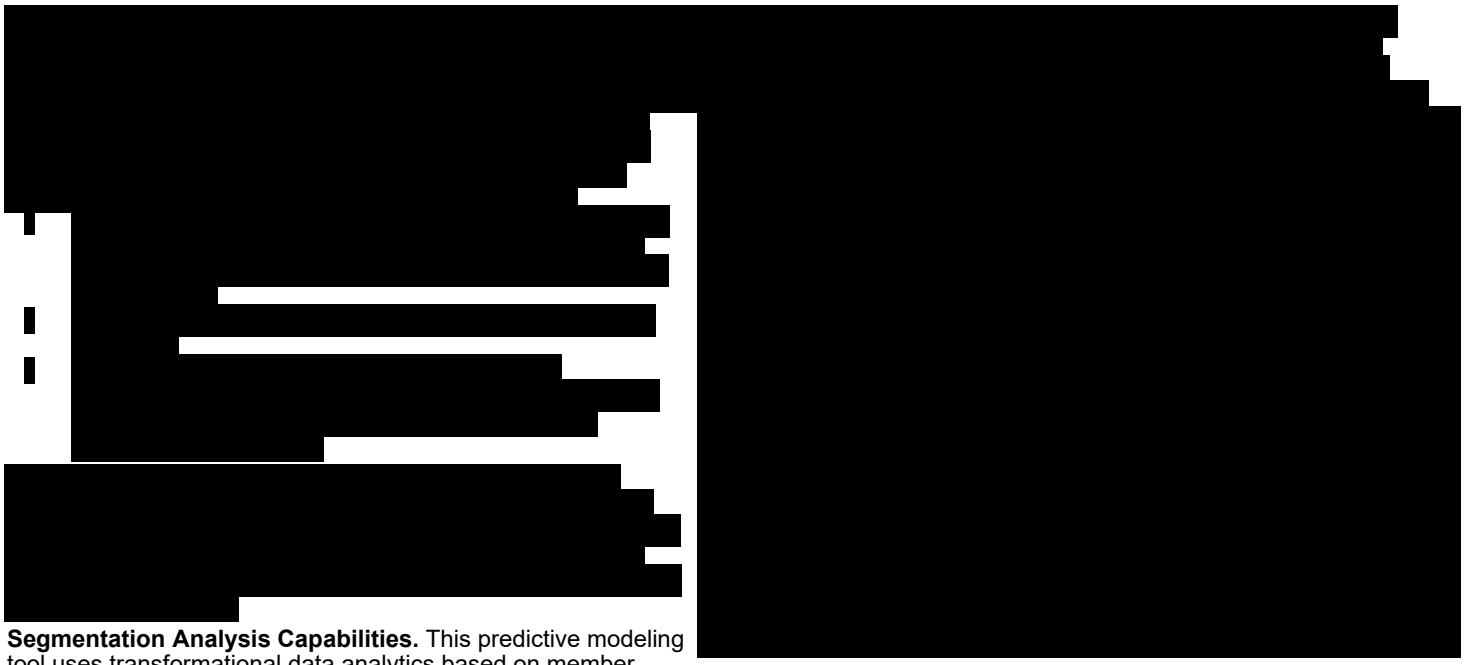
Integrating Technology to Improve Care

In addition to using data and evidence-based support tools in the care management processes described previously, we integrate technology across a range of additional strategies to improve care.

Admission, Discharge, and Transfer (ADT) Data. For example, we use ADT data technology to identify when members are admitted or discharged from the hospital or Emergency Services. With data received from ADT feeds, members of our Care Management team collaborate with members of the UM and long-term services and support teams to reach out to members that are hospitalized or have been seen in the ED, if we have not previously been made aware. We especially use this data to focus on patients who leave against medical advice from a care setting. This data helps to fill the gaps in communication that may inadvertently and unintentionally occur and enables us to make sure members get the level of services they need. Data allows us to identify such gaps and make sure that members get the authorization they need for service upon discharge. These data feeds are also designed with flags for patients who have been readmitted to the hospital or who have been seen in the ED three times in the last six months.

Population Health Analytics. This innovative tool offers insights that we use to develop new services and programs based on identified population conditions and social barriers to care. It aggregates member data, including geographical density, claims data, chronic physical or BH conditions, maternal health statuses, admission rates, and utilization rates to trend member experience over a 12-month span. The tool's flexible search options enable the user to drill down to the desired information (for example, a search for

counties where there is a high density of individual members with diabetes, high-risk pregnancies, or food insecurity). Armed with this information, we can identify and develop new services that will bring the most benefit and value to Nebraska Healthy Blue members and the State.



Segmentation Analysis Capabilities. This predictive modeling tool uses transformational data analytics based on member utilization data, assessments, ADT, and other medical record data to proactively identify the level of support each member needs. As part of our population health approach, we leverage this tool to assure we meet members where they are and provide support for the best possible health outcomes.

Care Management Trends. We collect and use a range of member-, provider-, and community-level data to inform our quality management (QM) and population health strategies and establish priorities for interventions. Our analytics engine aggregates data from multiple sources, so we have in-depth insight into all aspects of population health to take steps proactively. We leverage qualitative and quantitative data, using internal sources including claims, utilization, demographic, and data from external sources including:

- Published, peer-reviewed research
- Nebraska-specific public health data
- Any available data from Nebraska MLTC
- Integrated electronic health records data from providers (as available)
- Data from national and local organizations, such as our community-based referral platforms and local nonprofits that promote public health through projects in policy evaluation, community health, data analysis, and health access

Predictive Modeling for Optimal Outreach Trends. We use enhanced technology through our predictive modeling tool to provide outreach based on how members want to be engaged. Our quality analytics platform's new tool will leverage data science and predictive analytics to recommend the most effective strategies for improving member health outcomes and quality scores. This tool will integrate multiple information streams related to HEDIS results, improvement interventions, and member-level data into a set of easily navigated dashboards that will be accessible to staff throughout our health plan to inform and optimize program strategies. This data analytics enhancement will improve our longitudinal view of members, their clinical history, and their communication preferences. The tool analyzes metrics and recommends member engagement strategies most likely to resonate with targeted populations or individuals. Our QM, Care Management, BH, and provider experience teams will use this data to infuse quality improvement approaches in closing care gaps across all functional areas.

Data for Providers. We will also give providers actionable, timely, and accessible data to assess their performance in our value-based purchasing (VBP) programs and drive performance improvement, including population-specific health improvement opportunities and identified disparities via the following data-sharing tools:

- **Care Management Platform (Health Intech).** Access to member data in an easy-to-navigate dashboard will be available to all network providers through our provider portal. Data includes HEDIS care alerts, authorizations, prescriptions, and claims organized by type (inpatient, ED, and office visits).
- **Provider Care Management System (PCMS).** Available to providers who participate in Category 3+ programs. Using PCMS, providers will view actionable, member-specific information, including care gaps, to enable them to examine current performance and identify members needing outreach and engagement.
- **VBP Provider Scorecard and Reconciliation.** Scorecards show provider performance relative to quality and cost measures and targets. Providers who participate in our Category 3 programs also will receive reconciliation reports indicating the status and results of their incentive program.
- **Financial Recovery Groups Medical Economics Platform.** AccuReports® enables providers to trend present performance to historical month-to-month and year-over-year data. Included information comes from multiple sources in a drillable format (such as top 10 utilizing members) with customizable dashboard graphs, enabling users to quickly spot trends, understand the drivers, and act on opportunities to improve performance. This platform is updated daily and is available to all network providers.

- **Transformation Action Plan.** Provides comparative performance information. Helps identify opportunities and actions to improve quality outcomes (such as preventive health services and chronic condition management) and reduce unnecessary utilization (such as avoidable ED visits). Action plans are updated by Care Delivery Transformation (CDT) Care Consultants monthly and provided to PCPs that participate in our Provider Quality Incentive Program (PQIP), PQIP Essentials, and Risk and Shared Services (R/SS) Category 3 VBP programs.
- **QM Reporting Suite.** This tool includes detailed population health metrics, relevant utilization patterns, HEDIS results, pertinent total cost of care metrics, and comparisons to peers and benchmarks. CDT Care Consultants and QM Representatives can generate reports from this platform and provide them to network providers as requested.

Integrating Tools, Data, and Systems to Integrate Outcome- and Value-oriented Payment Models

The PQIP rewards our valued providers for the quality care they provide our Medicaid members. Using a system of HEDIS measures, PQIP seeks to encourage efficient, preventive, and cost-effective health care practices. As noted previously, network providers in value-based programs gain access to claims data for their attributed members via PCMS, a web-based reporting application created to deliver additional claims-based data to providers and their care teams. It provides meaningful and timely information to providers to help in delivering high-quality care to patients.

Healthy Blue has implemented several additional VBP programs, described in detail in our response to #94, as a means of partnering with our providers to improve member care.

[redacted]

Collectively, the tools described previously support evidence-based decision making, both internally and with our providers and stakeholders, and help to design and adapt programs that drive quality outcomes for our members.

No. 62

Healthy Blue's Plan for Coordinating Efforts for Members Engaged in State Programs

We value the relationships we have built working with DHHS and its divisions in support of coordinating care for our Nebraska members. We will continue our coordination efforts that leverage our experience delivering care and case management to members receiving services from a variety of DHHS-administered programs. We will continue to designate a Healthy Blue dedicated point of contact for each agency or program we work with to facilitate collaboration and planning and to establish procedures for coordinating care. As part of this process, we develop workflows, referral processes, and information sharing procedures.

Healthy Blue's approach to coordination is holistic: We identify and address all member needs regardless of who pays or administers the benefit. We actively coordinate each member's care for as long as the member is enrolled in Healthy Blue.

When we identify a member receiving services, including care coordination, through a DHHS-administered program, and with permission from the member, the Care Management team initiates contact with State coordinators or appropriate staff based on the established coordination procedures. We discuss next steps, coordinate multi-disciplinary care team meetings, and engage in collaborative care planning and coordination. We ask members to identify their program case manager, waiver service coordinator, or other primary staff contact and to consent to our coordination with them in support of development of a comprehensive care plan that includes the services accessed from State programs. With member permission, and in compliance with HIPAA, we share screenings, assessments, care plans, and other member-specific information needed to support coordination with our state partners. We incorporate information we receive in the member's record in our care management system, Health Intech. We include State staff and all members of the multi-disciplinary care team in post-discharge planning to further assure continuity of care and coordination of services during transitions in providers, levels of care, or as members age in or out of specific benefits.

We also offer supports to members that help them navigate the health and social services systems. [redacted]

Ongoing Collaboration Promotes Access to Care

To make sure our approach is well-coordinated and promotes access to needed services and supports from all available sources, we work closely with DHHS and its divisions, providers, and vendors.

Division of Behavioral Health. We collaborate with Division of Behavioral Health (DBH)-funded programs such as the Nebraska System of Care for Youth, Behavioral Health Network of Care, and the Nebraska Behavioral Health Regions to connect members with complex needs, including behavioral health (BH) and substance use disorder needs, to medically necessary services and social and community supports. [redacted]

Healthy Blue's clinical leadership also participates in several DBH-funded projects designed to enhance Medicaid services, such as the DBH-sponsored Assertive Community Treatment (ACT) Training and Matrix Intensive Outpatient Substance Abuse Treatment Program's (IOP's) two-day training to learn about Matrix IOP and strategize about how to best make this available to members. Leadership has continued participation in meetings to strategize and coordinate enhanced service delivery, meeting individually with each ACT team face-to-face to troubleshoot areas of improvement and to support efforts in providing quality ACT services.

Division of Children and Family Services. Healthy Blue collaborates with Division of Children and Family Services (DCFS)-funded programs to support the safety, permanency, and well-being of children in the care and custody of the State. Our clinical leadership and Care Managers (CMs) participate in staffing meetings scheduled by DCFS or DHHS on an as-needed basis to discuss State wards with complex needs and/or who are encountering difficulty with placement. These meetings include Dr. Janine Fromm, the Executive Medical Officer at DHHS. We collaborate to understand how we can better assist DCFS with service and care coordination to meet members' behavioral, medical, and SDOH needs. As a result of these meetings, our leadership team — BH Clinical Director Dr. Wetzel, BH Manager Shannon Calabrese, and Tribal Member Advocate Teresa Zahren — meets monthly with DCFS leadership, Karen Moran, and Alison Wilson to support ongoing communication and collaboration. They coordinate access to care, and our care management staff are available to assist State guardians and foster parents in meeting the needs of children and youth with complex and high-risk BH needs. The BH Care Management team collaborates with APS and CPS as needed. We work to meet the needs of members at risk and with complex BH, substance abuse and medical needs. Our team initiates care conferences and multi-disciplinary team meetings with the assigned APS/CPS worker and larger treatment team, as necessary, in order to determine the most appropriate community resources and ensure each team is meeting the needs of the member without duplicating services.

Our Foster Care team includes three CMs who have experience working with children and adolescents with special physical health and BH needs, and we will be adding a fourth as part of the new contract. We receive a weekly report of newly enrolled members in foster care and immediately assign them to one of our CMs. The CM obtains the member's medical records, history, and case worker contact information; contacts the case worker to coordinate care and case management activities; and implements collaborative care planning. We focus on helping foster parents and their foster child to access needed health care services, including evidence-based BH services, such as parent-child interaction therapy, functional family therapy, and multisystemic therapy. We also connect foster parents to telehealth options such as LiveHealth Online, described in our response to Section V.E.21, to address provider shortages, especially child psychiatrists, and speed up access to care.

Division of Developmental Disabilities. Our Care Management team promotes collaborative planning and care coordination for members receiving services through one of Nebraska's four home and community-based services (HCBS) waivers, including the Comprehensive Developmental Disabilities Waiver, Developmental Disabilities Adult Day Waiver, Aged and Disabled (AD) Waiver, and Traumatic Brain Injury Waiver. Nebraska is not alone in its struggle to address lengthy waiting lists for HCBS waivers. We are dedicated to supporting members across the continuum of care so they can maximize their health and independence through the combination of Healthy Blue covered services and HCBS waiver services. We identify waiver-enrolled members during contact with the member, their family member, or caregiver as applicable; and from a referral from a HCBS waiver service coordinator, provider, our utilization management (UM) staff, or other internal or external source. Members receive the level of care and case management support they need from the Healthy Blue Care Management team, which may include assignment to a CM as described in our response to Sections V.E. 51 and 52. Our Care Management team also works with organizations such as the Department of Vocational Rehabilitation, Commission for the Blind and Visually Impaired, Commission for Deaf and Hard of Hearing, Munroe Meyer Institute, League of Human Dignity, and the Nebraska Assistive Technology Partnership (ATP), to help our members access health and social services to meet their holistic needs. Because HCBS are critical to helping members remain in their home and participate in community living, we refer members who may be eligible or who request these services to DDD and help the member in completing an eligibility application upon request.

Our CMs and UM Clinicians make sure we do not duplicate activities provided under the HCBS waivers. They exchange information with a member's service coordinator to support collaborative care planning and service authorization without duplicating those activities that are carried out by the service coordinator. CMs review existing waiver assessments and care plans when available to minimize the amount of information we need to gather from the member. CMs also collaborate to deliver services that may be provided through a combination of Healthy Blue, waiver, and community resources. For example, one of our CMs worked with the ATP for a member who needed home modifications due to a disability. They collaborated with the member's waiver service coordinator when the cost of the member's home modifications exceeded the amount covered under the waiver. Together, they contacted the League of Human Dignity and Easter Seals of Nebraska to supplement ATP's assistance.

LHD/State Unit on Aging

We work closely with community agencies, such as Area Agencies on Aging (AAAs) and the League of Human Dignity, to coordinate members' services with AD Waiver service coordinators and with services that may be available to our members through the Older American's Act, including nutrition services. Our Care Management team maintains direct contact with the AAAs to make sure services are well coordinated, accessible, and appropriate for our members and not duplicative.

Department of Public Health

Our Care Management team helps potentially eligible women, infants, and children access services provided through WIC, including monthly benefits to purchase healthy foods, nutrition education, and breastfeeding support. We refer these members to their local WIC clinic and provide appropriate medical information to promote coordination of care. For members engaged in our OB care management program, the OB CM makes referrals for nutritional assistance and other needed community resources as part of comprehensive care coordination. We help members with HIV/AIDs navigate available resources, such as the Ryan White Program Parts B and C, AIDS Drug Assistance Program, and the Housing Opportunities for Persons Living with AIDS program. Additionally, we coordinate with the Department of Public Health on access to NESIS the vaccine registry.

Information Sharing with DHHS-administered Programs

Our Care Management team facilitates information sharing between a member's providers, including HCBS providers, external case managers, HCBS waiver service coordinators, and other program staff as allowed under HIPAA. We review and integrate member-specific information, including existing care plans and service plans, permanency plans, and other relevant documents received from DHHS-administered programs into the member's record in Health Intech, so these are available to our clinical staff. Our SFTP enables secure information sharing compliant with all applicable privacy laws and regulations and safeguarded through business associate agreements. We actively take part in secure data exchange to better coordinate care. In addition to sharing copies of member-specific information with DHHS-administered program staff as permitted, we exchange important information during multi-disciplinary care team meetings, during ad hoc calls, through secure emails, and during other coordination activities.

No. 63

Outreach Program to Encourage First Trimester Prenatal Services

Healthy Blue provides a comprehensive suite of culturally competent solutions dedicated to promoting and supporting the health of pregnant members and their babies. Our strategies, including early identification of pregnant members, personalized outreach and engagement, timely screening, and connection to comprehensive services help to assure that pregnant members initiate care within their first trimester, or seven calendar days after enrolling in Healthy Blue. ***These perinatal care interventions have led to significant improvement in timeliness of prenatal and postpartum care*** as demonstrated in Figure V.L.63-1. We will continue to support Nebraska's goal of improving birth outcomes and reducing maternal and infant morbidity and mortality and provide leadership in this area. For example, our Chief Medical Officer, ***Dr. Debra Esser, serves on the Board of the Nebraska Perinatal Quality Improvement Collaborative (NPQIC***).

[redacted]

Identifying Pregnant Members

Healthy Blue identifies pregnant members through the Notification of Pregnancy (NOP) process, State enrollment files, claims data analysis, medical management data, and referrals. These referrals come internally from Member Services staff, the 24/7 Nurse Helpline, BH service line, CMs, or UM staff and externally from the member themselves, family, provider, and external case managers and agencies. We review all enrollment files to identify members who are pregnant and alert our clinical team about new pregnant members for risk screening and assessment. We educate our employees across all functional areas about the importance of quickly identifying and connecting pregnant members to care coordination.

Education and Incentives to Engage Members in Early Prenatal Care

We offer all pregnant women proactive care coordination services and access to the Care Management team, including Healthy Blue's New Baby, New Life℠ program which includes pregnancy and condition-specific educational materials, enhanced services, incentives, and tools. Through the member portal we post the *Pregnancy and Beyond Resource Guide*, which provides pregnant members with information about benefits, how to keep healthy throughout their pregnancy, and the importance of prenatal care in the first trimester.

[redacted] in the first trimester or within 42 days of enrollment. We also offer nonemergent medical transportation for all prenatal care visits. To encourage and support pregnant members in completing their prenatal care, we offer the My Advocate™ tool to members. ***My Advocate delivers maternal health education by smart phone app, website or IVR; tracks prenatal appointments; and sends twice-weekly communications, including appointment reminders and assessment surveys tailored to the stage of pregnancy.***

Supporting Community Organizations in Prenatal Outreach and Improving Health Equity

Healthy Blue partners with numerous community organizations that work with pregnant women to help assure first trimester prenatal care. A key intended outcome of these partnerships is to mitigate disparities in Black maternal and infant care and outcomes. Healthy Blue financially supports and is developing bi-directional referral relationships with the ***Malone Center in Lincoln, the Omaha Better Birth Project, and the Omaha Black Doula Association.*** With outreach and programming led by Black, Indigenous, and people of color, these organizations provide prenatal education, empowerment, support, and health care resources before, during, and after childbirth. Through a new partnership with ***Quilted Health***, Healthy Blue will make Doulas available to all pregnant members who desire one and provides matching services to link women with advocates from similar communities, backgrounds, and belief systems.

Healthy Blue leverages community partners to conduct events, including Baby Showers. We conducted 30 Baby Showers between January 2021 and May 2022 which were virtually and in locations including Crawford, McCook, Lexington, Lincoln, Macy, Norfolk, Omaha, Ogallala, Scottsbluff, and Wayne. In collaboration with partner ***churches, community-based organizations, Head Starts, WIC programs, health departments, and community colleges***, our Baby Showers focus on prenatal education including linkages to prenatal care and other local resources, as well as post-partum education including breastfeeding.

Healthy Blue's Community Investment in Improving Maternal Health

Healthy Blue has committed **$250,000** to partner with Pathways Community HUB Institute in a two year pilot to support an evidence-based care coordination model that helps at-risk moms and moms-to-be deliver and raise healthy babies.

NE_HH22_CommunityInvestment_Q63_COB_01

We also provided $100,000 to the UNK Rural Measures Project to help expand broadband internet in Nebraska; staying connected promotes health, wellness, and social support needed to improve health equity for pregnant women. Connectivity is also critically important for continuing education, for obtaining or maintaining a job, and for accessing benefits and services.

Healthy Blue, CHI Health, and the other Medicaid health plans in Nebraska have partnered to collectively commit $1 million to the Pathways Community HUB Institute (Pathways) for a two-year pilot to help at-risk moms and moms-to-be deliver and raise healthy babies. Pathways has developed an evidence-based model to coordinate care by training community health workers to connect families to social and medical services, such as prenatal classes, jobs, housing, and transportation.

Incentivizing Providers in Prenatal Care Outreach and Retention

[redacted]

[redacted]

[redacted]

Screening Pregnant Members

Once we identify a pregnant member, we initiate the Health Risk Screening within three days by inviting them to complete an OB screener by telephone, text, or mail or through the member website. Additionally, the My Advocate tool sends an e-mail to the member to introduce the screening followed by an Interactive Voice Response screener using 10 call attempts. The OB screener on My Advocate interfaces directly with our care management program for member risk stratification and future outreach.

The more predictive screening questions are located at the beginning of the OB screener so we can identify high-risk pregnant members early on, in the event they do not complete the screening. If a member does not complete the OB screener, we have a specialized Community Health Worker (CHW) or Doula visit them in the community to establish trust, complete the screening, and evaluate any unmet social needs that may impede their ability to engage in care coordination and prenatal care. Our OB screener includes five predictive models. In developing these models, we evaluated a wealth of data sources covering claims, authorizations, enrollment, labs, diagnosis history, risk scores, and demographic and SDOH information, including age and race/ethnicity.

[redacted]

We use the screening results to stratify members into care management or our high-risk OB care management program. Both the OB screener and NOP identify women with elevated risks, including the risk for delivering an infant requiring NICU admission based upon history of preterm labor or birth, prior baby with low birthweight, or the member's diagnosis of hypertension or diabetes. We automatically identify pregnant women as "high-risk" if they have hypertension, a history of preeclampsia, or a preterm delivery less than 35 weeks estimated gestational age.

Coordinating Care to Connect Pregnant Members to Services

Upon receipt of a new referral, the assigned OB CM reviews all available member information including risk screening results, referral information, Healthy Blue program history (care management, DM, care coordination, UM), claims and pharmacy history. Our OB CMs conduct initial outreach to complete a Comprehensive Health Assessment to determine individual strengths, needs, and health risks and help the member access the interventions, services, and supports commensurate with their needs and risk level. ***We assign these pregnant members with elevated risk and others identified with urgent needs for immediate outreach by an OB RN Care Manager.*** The CM will make telephonic or face-to-face contact as soon as possible and within one business day of the receipt of the assignment. If the referral is routine, the CM attempts to initiate verbal, written, or face-to-face-contact with the member within five business days. If we are unable to contact a pregnant member during the initial outreach, our CHWs will make a minimum of three attempts within 14 calendar days of receiving the assignment to contact the member through a combination of telephone calls, letters, or face-to-face visits. If we exhaust these outreach attempts, we may initiate referrals to appropriate community-based organizations, such as Doula organizations, to engage the member. We document all outreach attempts and follow-up activities in Health Intech and will be available for State review upon request.

Mobile Apps and Virtual Options Keep Members Engaged in Care

[redacted]

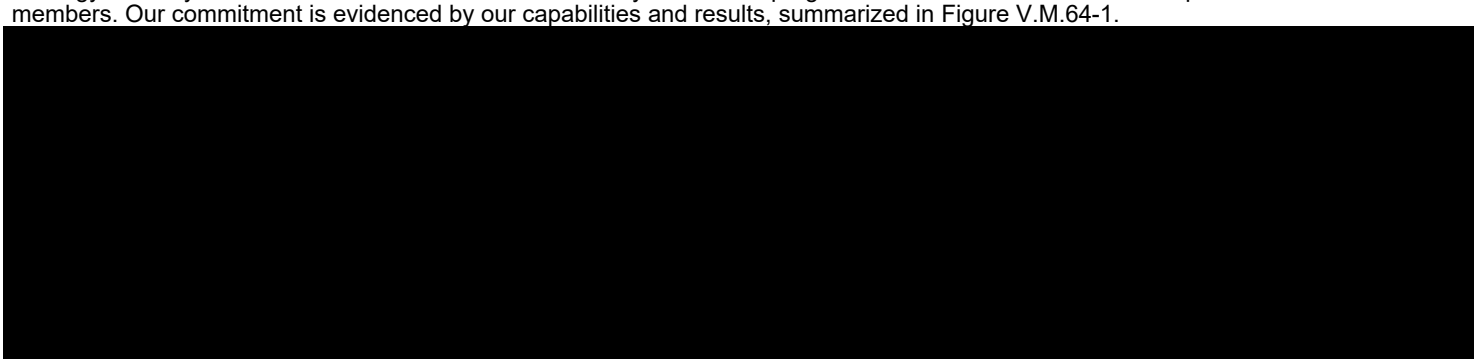
Supporting Pregnant Women Who Opt Out of Care Coordination Services

Our staff are all trained to inform members of their right to refuse assistance or opt out of OB care management services and the implications of such refusal relating to benefits eligibility and/or health outcomes. Our CHWs will make ongoing attempts to connect with the member monthly throughout the pregnancy to assure early and regular prenatal care.

No. 64

Our Quality Commitment

Healthy Blue brings a deep understanding of the State of Nebraska; the needs of its people; and innovative, evidence-based strategies to advance health equity and achieve quality improvement (QI) results. Our Quality Assessment and Performance Improvement (QAPI) methods are an essential part of how Healthy Blue meets the needs of our members, our providers, and our community partners to achieve MLTC's goals and objectives and is in alignment with the Nebraska Quality Strategy. Our local experience is augmented by our parent company's 31 years of Medicaid managed care experience and backed by a seasoned team of health care professionals with combined tenure exceeding 250 years. Among these employees are recognized leaders like Dr. Robert Rhodes and Dr. Martin Wetzel, who provide the foundation for the continuous measuring, evaluating, and refining of our program in alignment with the MLTC Quality Strategy. Healthy Blue listens to the voice of the community and our QI programs to achieve results that are important to Nebraska members. Our commitment is evidenced by our capabilities and results, summarized in Figure V.M.64-1.



QI Structure and Accountability

Healthy Blue meets the QI program requirements set forth by the MLTC and NCQA standards. Our QI/quality management (QM) program descriptions, work plan, and program evaluation are exclusive to Nebraska and consider the needs of the populations enrolled and the Nebraska-specific health landscape and challenges. Our QM program clearly defines specific goals and activities to drive results over a 12-month period, representing our road map for the year. Clear policies and procedures outline methods, timelines, and responsibilities for completing quality activities. QM is an ongoing, comprehensive, and integrated system for monitoring and evaluating the quality, safety, and appropriateness of medical health care and behavioral health (BH) care and services objectively and systematically. This QM process identifies and acts on opportunities for improvement. The QM program addresses issues related to QM and quality performance measures for both State and national compliance and is a cohesive plan for addressing member needs across the continuum of care. Additionally, Healthy Blue makes all information about its QI/QM program available to providers and members.

Additionally, our comprehensive QI/QM program includes:

- Quality policies and procedures and process guidelines and tools that provide the basis upon which the QI/QM program operates, timelines, methods, and who is responsible for each task
- A process to monitor under- and overutilization, including variation in practice patterns to identify outliers
- Adoption of evidence-based medical necessity criteria and clinical practice guidelines to be used uniformly in the utilization management (UM) process to promote effectiveness of treatment services, symptom reduction/management, and functional status
- Review of the prescribing patterns of network prescribers to 1) identify patterns of prescribing that deviate from current clinical practice guidelines and provide support and education to providers who are found to be outliers; and 2) identify members whose utilization of controlled substances warrants intervention, including the prescribing of psychotropic medication to children
- Processes to collect and verify the accuracy, validity, and reliability of data for QI/QM activities
- Systems to support and report for all QI/QM activities, including the use of DHHS' Health Risk Assessment information, survey tool, dashboard, public data, quarterly results, special needs population assessments, QI initiatives, HEDIS®, CAHPS®, value-based purchasing contract performance, and other Healthy Blue QI activities in full compliance with Section 1139B of the Social Security Act or as required by the Agency or CMS
- Processes to check the reports for quality of the information
- Processes to assess member satisfactions and programs to incent members that align with the Agency's goals and other quality outcomes

QI Program Infrastructure

There are dedicated resources for management of our quality program as shown in Figure V.M.64-2. Our organizational infrastructure provides effective monitoring, reporting, and analysis, and acts on opportunities to improve clinical care and services. Our Nebraska-based ***QM Coordinator, Janet Endorf-Olson, RN***, manages and oversees QM/QI activities and keeps our goals on target. Additionally, our data-driven and NCQA-accredited QM/QI strategies are based on years of experience measuring, evaluating, and refining the Nebraska Health Link program. We continuously assess quality data, utilization patterns, and year-over-year performance measures to develop innovative strategies that improve health outcomes for members, support network providers, and drive health plan performance. Our initiatives include text messaging to promote wellness, provider incentives for improved member outcomes, and population health data analytics that quickly identify disparities and high-risk members through a comprehensive view of service utilization, social determinants of health (SDOH), and stratified demographic data.

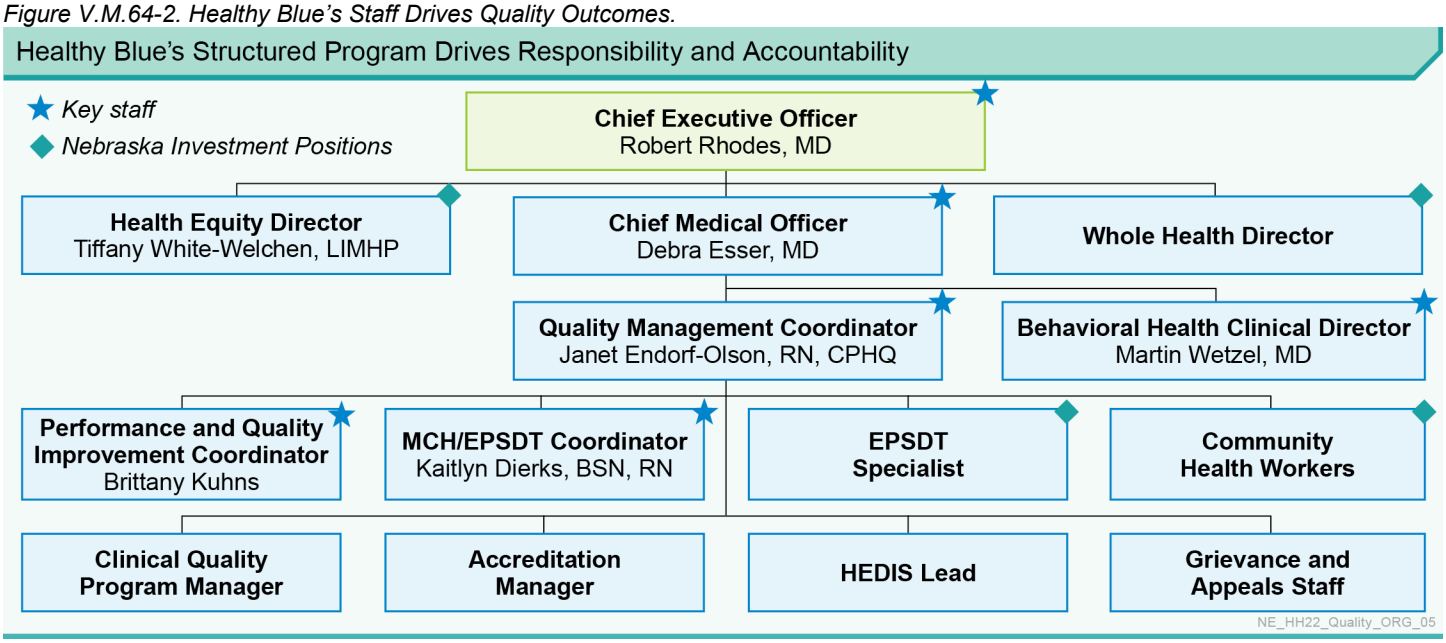
All senior leadership supports a culture of continuous QI and are members of the Quality Assessment and Performance Improvement Committee (QAPIC). The QAPIC includes CEO Dr. Robert Rhodes, Chief Medical Officer, Dr. Debra Esser; our QM Coordinator, Janet Endorf-Olson; Health Equity Director Tiffany White-Welchen, LIMHP; and leaders from our Population Health, BH Services, and Provider Services teams. The QAPIC will also include members from the community and network providers. Dr. Esser and Ms. Endorf-

Olson oversee the QAPIC, which provides multi-disciplinary and cross-functional direction and oversight of all QAPI and population health initiatives. Figure V.M.64-2 shows the Healthy Blue organizational structure to drive quality.

To assure that members receive timely, appropriate, and quality services from our subcontractor partners (subcontractors), we will leverage our robust Subcontractor Oversight program, led by a local Nebraska Vendor Oversight Manager. Our collaborative, agile, and transparent oversight processes will deliver operational excellence. Our oversight teams, tools, and protocols will enable us to continuously monitor partner performance via daily collaboration and formalized auditing processes. In addition, our local Contract Compliance Officer, Vendor Oversight Manager, and Compliance Committee verify that subcontractors comply with all applicable requirements and expectations to meet our quality standards. Our Compliance Committee meets quarterly with key partners to monitor performance against goals, objectives, and contractual requirements, as well as engage them in QI initiatives when appropriate. The Compliance Committee reports up to the QAPI for additional oversight and monitoring.

Our Vendor Oversight Manager has the primary responsibility for subcontractor compliance with Nebraska requirements. Examples of subcontractors our Vendor Oversight Manager oversees include Dental and Vision Benefit Management, Non-Emergency Transportation Benefit Management, and Survey Administration. The Vendor Oversight Manager works with our national Delegate/Vendor Oversight and Management Committee (DVOMC) to oversee compliance with all State, federal, NCQA, and CMS program requirements, standards, and expectations, as well as any other applicable regulatory and accreditation standards. Through annual assessments, we review and evaluate each partner's performance, including compliance with standards, and initiate a Corrective Action Plan if we identify deficiencies or gaps. The DVOMC reports quarterly to our national Quality Improvement Committee (QIC) and national Operational Compliance Committee.

Figure V.M.64-2. Healthy Blue's Staff Drives Quality Outcomes.



QAPIC Membership and Committee Responsibilities

Quality is part of our collaborative culture as a health plan, and we consider all Healthy Blue staff to be ***quality champions***. Our approach is rigorous, systematic, and designed to continuously improve results for all members and providers. All senior leadership supports a culture of continuous QI and are members of our QAPIC. The QAPIC includes medical leadership from physical health and BH. Subcommittees that report to the QAPIC include providers from the contracted provider network. The QAPIC meets quarterly and has formal written minutes that the committee reviews and approves.

The QAPIC oversees the development, approval, implementation, monitoring, and evaluation of the QM Improvement Work Plan and Program Document. Guiding our QM efforts, the QAPIC's mission is to promote quality health care and services and access to care in a safe, culturally sensitive manner while complying with requirements mandated by the MLTC, NCQA, and other related entities. The QAPIC:

- Provides a forum for all levels of Medicaid leadership to review and evaluate the quality, safety, efficiency, accessibility, and availability of care and services
- Provides oversight and makes recommendations for QM programs, improvement processes, and corporate-supported services
- Reviews and approves quarterly and annual health plan reports, national support services reports, and program policies and procedures
- Collaborates across departments on solutions to remove barriers for our Nebraska Medicaid members

While our local QM and QAPIC, which serves as our governing board, have direct oversight and monitoring of our QM program, they are complemented by our national Medicaid division, which supports us through the national QIC meetings that occur 10 times annually, promoting adoption of best practices from affiliates, such as boosting access through telehealth in rural communities. The QIC is our national organization's governing body that reviews and approves all NCQA-required quality reports, including clinical practice guidelines (CPGs), UM, credentialing, chronic condition management, BH, health care disparities, access and availability, and member and provider satisfaction outcomes. The QIC also provides oversight of QM programs, approves templates for required accreditation reports, and assures that NCQA standards and guidelines are met. Our MCO's senior leaders also serve as members of the QIC, including our local QM Director and Medical Directors. Written minutes of all meetings are obtained with a copy of the signed and dated written minutes for each meeting on file and made available for review upon request by DHHS.

Our committee structure emphasizes inclusion of stakeholders, such as providers, members, and community organizations, to develop sustainable interventions to meet DHHS's goal of improving quality outcomes and consistency of care across the delivery system. Healthy Blue's QM program fosters local decision-making that is enhanced by the knowledge and perspective of our national team for some functions (as shown in Figure V.M. 64-3). Reporting to our Healthy Blue Board of Directors and national Medicaid QI Committee, Healthy Blue Medicaid QAPIC establishes our own strategic direction to monitor, support, implement, and evaluate QM activities. Supporting the local QAPIC is an array of subcommittees that bring both local and national expertise.

Figure V.M. 64-3. Healthy Blue's Staff Is Dedicated to Improving Quality.

QI Roles and Responsibilities

QM Role	Responsibilities
QM Coordinator	• Manage entire QM/QI department and work collaboratively with our leadership, DHHS, and other MCOs and stakeholders.
Maternal/Child Health/EPSDT Coordinator	• Design programs to ensure timely EPSDT, promoting and implementing family planning services, preventive services, and prenatal and postpartum services. Identify and coordinate assistance for identified member needs specific to maternal/child health and EPSDT.
Clinical Quality Program Manager	• Manage process improvement initiatives, QI activities, and Performance Improvement Project (PIP) as well as continuous data analysis for HEDIS projects, facilitating HEDIS and PIP Taskforce and working collaboratively with functional leads.
Performance and QI Coordinator	• Oversee PIP design and implementation, including interventions and tracking data to identify trends and outcomes. Engage with DHHS and other MCOs to drive PIP performance collaboratively.
HEDIS Lead	• Track and trend all HEDIS data collection year-round, including claims-based data and supplemental data.
QM Data Analyst	• Collect and analyze data for QM on member and provider outcomes, including disparities data, care gaps, SDOH data, claims analysis, EPSDT services management, well-baby and well-child care assessments, immunization services, and grievances and appeals. • Data analysis will be continuous and include multiple sources to support health equity initiatives.
Grievance and Appeals Staff	• Maintain responsibility for reviewing, analyzing, and processing grievances and appeals to meet contract requirements and to help assure timely resolution for members and providers.
Accreditation Manager	• Lead our MCO through the NCQA accreditation process, including Multicultural Health Care and Health Equity Distinction.
EPSDT Specialist	• Implement the designed programs for EPSDT, including ongoing data analysis and tracking outcomes. • Work with other departments, members, providers, and community partners to identify and implement EPSDT activities.

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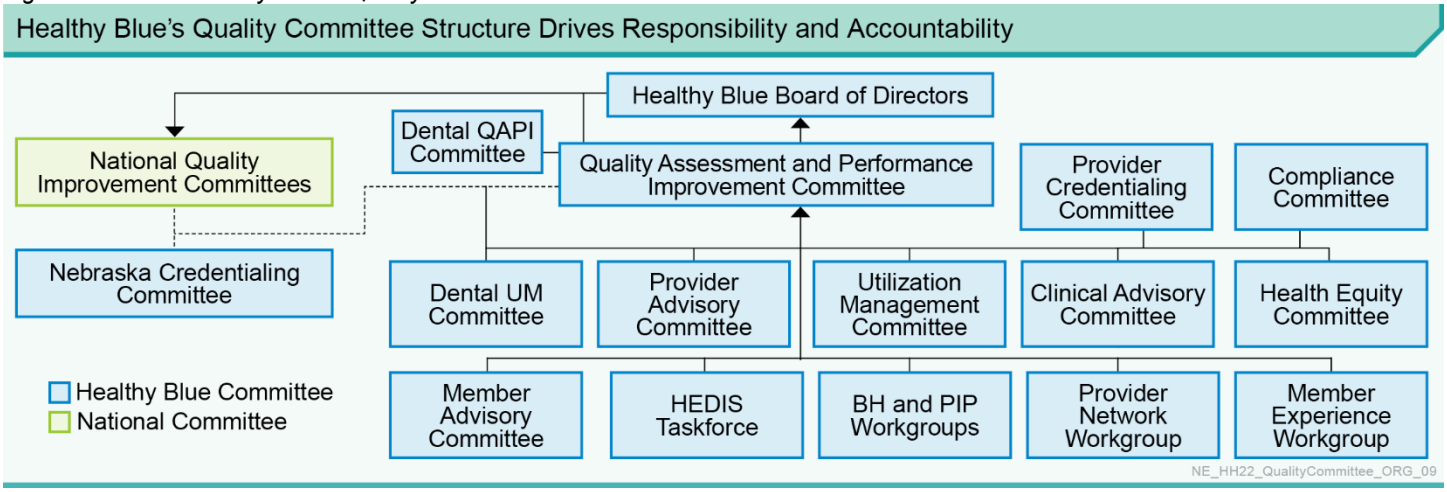
The QAPIC:

- Assures that QI initiatives include both individual- and system-wide activities that improve the quality of care and reduce health disparities
- Assesses member and provider feedback and satisfaction data, including CAHPS, Grievance System data, and member and provider feedback from advisory boards
- Remedies individual and systemic gaps in care by reviewing HEDIS outcomes by county and in aggregate
- Reviews over- and underutilization
- Identifies performance improvement projects (PIPs) and promotes rapid-cycle change
- Promotes cross-functional and continuous development of program improvements

An extensive subcommittee structure supports the overall QAPIC. The Clinical Advisory Committee meets to evaluate strategies related to clinical outcomes and drive improvements aligned to our population health priority focus areas. The Health Equity Committee evaluates all data related to health disparity, including maternal, infant, and child health; adult preventive care; chronic conditions; member satisfaction; and BH services. The committee tracks and monitors quality indicators; identifies disparities, barriers, and gaps in care; and develops interventions to address identified gaps. The HEDIS Taskforce looks at the HEDIS performance and interventions to drive improvement. Each of the subcommittees reports to the QAPIC for direct oversight and monitoring of QI activities. Figure V.M.64-4 depicts the quality committee structure at Healthy Blue.

Healthy Blue will establish a ***Dental QAPI Committee***. Our Dental Director will facilitate and provide oversight of the Dental QAPI Committee and collaborate with our current QI Infrastructure. The Dental QAPI Committee will leverage our long-standing history with implementing a robust and well-rounded QI program and committee structure in compliance with NCQA and MLTC requirements. We understand the importance and value of this structure to execute and oversee work plans to meet goals that are prioritized in alignment with MLTC's goals and objectives. We currently operate more than 10 committees, workgroups, and taskforces.

Figure V.M.64-4. Healthy Blue's Quality Committee Structure.



QAPIC Committees and Workgroups Facilitate Interdepartmental Commitment to QI. Supporting the QAPIC, subcommittees and health plan workgroups focus on driving QI. The following committees and workgroups report to the QAPIC, meet at least quarterly, and inform the QM program:

- **Clinical Advisory Committee (CAC).** Our CAC engages local physical health and BH providers as well as providers representing the other types of services our members receive. Dr. Rhodes, Dr Wetzel, and Dr. Esser drive provider engagement and recruitment, and this is also supported by our Provider Experience team. This committee reviews and provides input on QM activities, claims trends, and other significant developments; approves CPGs to confirm local Nebraska practice context; approves UM criteria, program evaluations, and descriptions; and reviews information about appeals, grievances, pharmacy updates and recalls, credentialing updates, and peer review for quality of care issues. The CAC conducts peer reviews to assess provider quality of care issues and discusses plans of action. The committee also monitors practice patterns and drug utilization to verify appropriateness of care as well as improvement and risk prevention activities, including review of clinical studies, development and approval of action plans, and recommendations for QI studies. Members include our Medical Director; BH Medical Director; QM leaders; and seven network providers, including one psychiatrist, one internal medicine physician, one OB-GYN, one family nurse practitioner, and three family medicine physicians.
- **Utilization Management Committee (UMC).** Chaired by our Medical Director, Dr. Esser, and our Director of Integrated Care Management, Tamara Mostek, our UMC oversees all UM and SDOH program activities and processes, including delegated clinical services. The committee reviews, monitors, and evaluates UM program compliance with Healthy Blue standards, State and federal laws and regulations, contractual requirements, and NCQA standards. The UMC reviews the annual UM and Population Health Management program descriptions and work plans; assesses the program's overall effectiveness, including long-term inpatient stays; monitors grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities for recommendations; and focuses on both physical health and BH continuity of care.
- **Health Equity Committee.** Chaired by our Health Equity Director, participants representing members, advocates, providers, and representatives of community organizations inform and guide our efforts to create a more equitable health care experience. The committee will also focus on rural area disparities to improve quality of care and reduce health disparities for members in underserved areas, as well as meeting members SDOH needs.
- **Member Advisory Committee.** Promotes a collaborative effort to enhance the MCO's patient-centered service delivery system. Its purpose is to provide input and advice regarding the MCO's program and policies. Healthy Blue staff encourage member participation across the State; our Care Management and Community Relations staffs promote active participation. For in-person meetings, Healthy Blue offers a gas card to attendees in addition to serving them lunch.
- **Dental QAPI Committee.** Chaired by our Dental Director, this committee promotes a collaborative effort from health plan leadership, members, and providers to direct and review QI activities and assure the Dental QAPI activities are implemented, data is tracked and analyzed, goals and key performance indicators are defined, and strategic direction and oversight are provided. Along with other key leaders, our Dental Management Coordinator and Vendor Oversight Manager will be active participants in this committee.

Additional advisory committees and workgroups include:

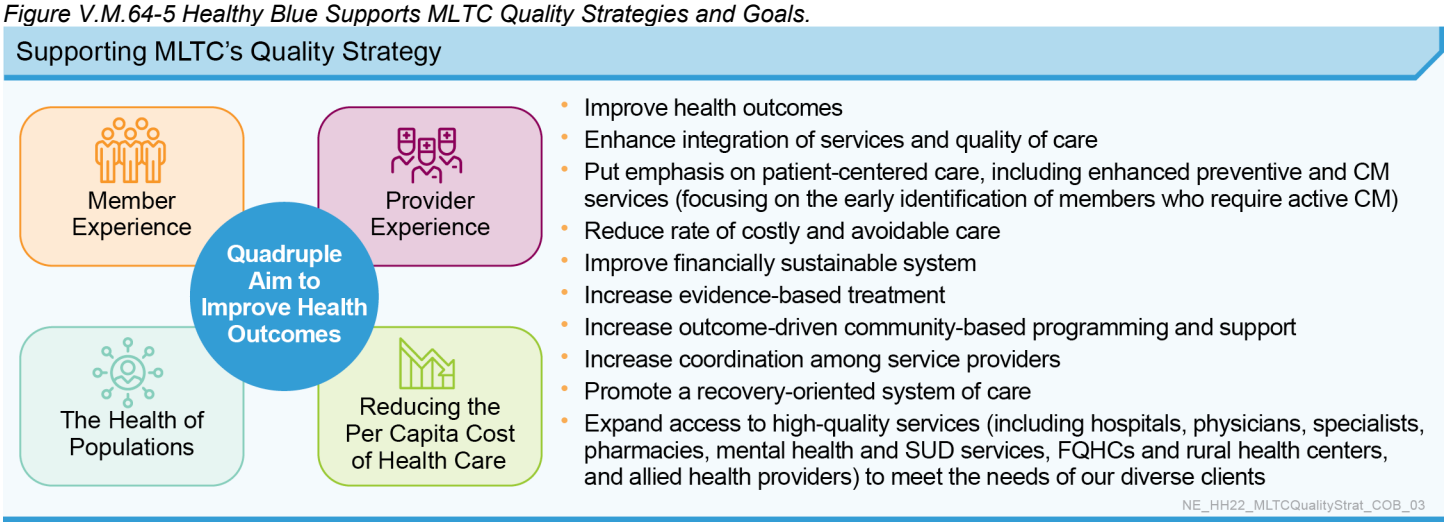
- **HEDIS Taskforce.** This taskforce is responsible for strategies development, deployment, and monitoring to achieve outcome goals. The roles and responsibilities of the taskforce include review of critical measures and current status to drive improvement; strategic planning on how to improve and initiate development; assignment of tasks, business owners, and timelines; development of gap solutions and identification of root causes; and ongoing monitoring of intervention progress and nearness to goals.
- **PIP Workgroup.** The PIP workgroup is responsible for overseeing and monitoring all Healthy Blue PIP projects, including tracking of performance indicators and development and monitoring of interventions. This workgroup uses key QI framework principles, such as the Plan-Do-Study-Act methodology and root cause analysis.

Supporting MLTC's Quality Strategy

Healthy Blue constantly pursues solutions, innovations, and capabilities that maximize our performance and outcomes, and that support ***the Quadruple Aim framework*** and MLTC goals (as shown in Figure V.M 64-5.). Our QAPI program objectives and our policies and procedures are designed to comply with Nebraska DHHS MLTC quality strategies and goals. This has been applied to all operational

departments within Healthy Blue and applies across benefits, whether physical health, BH, substance use disorder (SUD), oral health, or dental care. Policies, procedures, and program documents like the provider handbook have all been written to these standards.

Figure V.M.64-5 Healthy Blue Supports MLTC Quality Strategies and Goals.



We also maintain the systems and supports to comply with the data collection and quality reporting requirements. We have written our reports using the State's data definitions and service categorization. For example, the Provider Data, Architecture, Systems, and Quality (PDASQ) provides the infrastructure and process to oversee the integrity of the network database. We consistently report on time and are careful to assure the completeness and integrity of our data.

We comply with all audit and monitoring activities including, but not limited to working with External Quality Review agencies. We fully participate in PIPs.

Healthy Blue aligns its goals with the Nebraska State Quality Strategy and analyzes available internal and external data to identify focus areas. Data sources include, at a minimum: claims and encounters, authorizations, call center statistics, appeals and grievances, medical record reviews, care plans, HEDIS measures, CAHPS measures, case management audits, and provider satisfaction surveys. In addition, Healthy Blue collects data from the census, environmental, economic, social, and clinical/health care for the community to identify and reduce racial and ethnic health disparities in clinical areas. Healthy Blue's core mission is to provide high-quality care that improves our members' well-being as well as enhance population health outcomes for the communities we serve.

Healthy Blue annually conducts a population assessment by collecting, stratifying, and integrating various data sets and programs to assess its members' needs. The population assessment is used to:

- Assess the characteristics and needs of its member population, including SDOH
- Identify and assess subpopulations
- Assess the needs of child and adolescent members
- Assess the needs of members with disabilities
- Assess the needs of members with severe and persistent mental illness
- Review and update activities and resources to address member needs in each of the focus areas
- Review community resources for integration into program offerings to address member needs for each of the focus areas
- Stratify, identify, and address members' SDOH in each of the focus areas

[redacted]

Healthy Blue has a well-established member incentive program called Healthy Rewards. As part of our continuous QI methodology, we look for ways to enhance our member incentive programs to promote healthy behaviors and personal accountability and align with MLTC's targeted areas of performance. For example, by the start of 2022, we relaunched Healthy Rewards on a new platform that will increase member engagement through a single, unified experience within Sydney Health. The new platform offers additional options for redeeming rewards at national retailers.

Healthy Blue also has a full portfolio of provider incentive programs to advance our quality goals for improved outcomes. As part of our continuous QI methodology, we look for ways to enhance our provider incentive programs to promote QI and accountability. For example, we have developed a process for providers to access all aspects of the submission and status of incentives through a single sign-on platform. We are also introducing new provider incentive features to advance health equity. More information about our provider incentive programs is in our response to Question 94.

Complementing our QM interventions, Healthy Blue offers value-added services (VAS) that support MLTC's Quality Strategy for members, encouraging appropriate care and healthy behaviors and driving quality outcomes. Members can easily access and request these services on our new Benefit Reward Hub. Some examples of these VAS include:

[redacted]

Healthy Blue continues to introduce more member-focused QI programs and initiatives to broaden access to services, including:

- **Remote Member Monitoring.** Members with targeted conditions, such as chronic obstructive pulmonary disease, diabetes, or congestive heart failure, are provided with devices such as blood pressure cuffs, weight scales, glucometers, pulse oximeters, and pedometers. The tools are monitored remotely to identify falls and member vital signs outside parameters set by their providers and to identify signs of deteriorating status. An advance warning system enables the caregiver and provider to act swiftly if a member's vital signs fall outside the predetermined range and engage the Case Manager or provider when indicated. Such monitoring also allows earlier detection of medication nonadherence so that action can be taken to avoid deterioration.
- **Medication Management.** Pharmacists and Pharmacy Technicians with our Pharmacy Benefits Manager (PBM), IngenioRx, assess and address potential drug-related problems for members with multiple chronic disease states and medications. When a pharmacist identifies a potential drug therapy problem, the Pharmacist consults the prescriber to determine whether a change in therapy is appropriate. Specific programs include our BH Polypharmacy program, which targets multiple providers and multiple psychotropics; identifies care gaps; and increases medication adherence. Our Diabetes Polypharmacy program aims to increase medication adherence and address safety and care gaps in members prescribed more than 10 medications. Programs also include asthma new start education and medication review notes. For members who are not adherent, a Pharmacy Technician talks with the member to identify and address any barriers (such as side effects) and educates them about how to take their medications.

Healthy Blue partners with providers to increase access to care, provide holistic care, promote healthy lifestyles for our members, and increase member engagement while taking care to minimize necessary provider administrative effort. Our strategy includes giving providers the tools, resources, and support needed to serve our members, advancing the MLTC Medicaid Quality Strategy and driving improvement most efficiently and effectively in quality performance measures.

- **Provider Outreach.** [redacted]
- **Provider Performance Reporting.** Through our Provider Care Management System (PCMS), we provide actionable, member-specific information to enable our network providers to identify members in need, such as those members due for a preventive health service, including immunizations and cancer screenings. PCMS provides up-to-date information to support population health through alerts, icons, hover-overs, drop-downs, and drill-throughs. Providers can filter members by key conditions, risk factors, gaps in care, and visits. We distribute Care Gap reports monthly to PCPs that identify members due or overdue for preventive services, including well-child visits. We also provide a quarterly update that helps PCPs identify HEDIS-related gaps.

- **Performance-based Provider Incentive Programs.** Supporting our programs, CDT Consultants provide technical assistance to providers, serving as their navigators and performance coaches. They analyze provider performance based on quality metrics, utilization trends, and provider profile tools to help our providers identify improvement opportunities and solutions that can most easily be incorporated into their practices.
- **Identification and Documentation of SDOH.** SDOH provider incentive programs provide bonus payments to providers for completing SDOH member assessments, billing appropriate SDOH-related diagnosis codes, referring members to community-based organizations, and confirming that members received the help they needed. We incentivize providers to screen for SDOH risks by reimbursing for submission of certain ICD-10 Z codes, which indicate risks such as food, housing, and employment insecurity. This step provides an additional avenue for Healthy Blue to identify SDOH needs of Heritage Health members, allowing timely outreach by our outreach team.
- **Provider Training.** Our Medicaid Training Academy offers training to advance Healthy Blue Medicaid and MLTC's goals and objectives. Training topics cover: 1) integrated care to address member physical health, BH needs, and oral health; 2) population health management, including populations with Special Health Care Needs and SDOH risks; 3) value-based care and excellence recognition programs that reward providers for improving care quality and efficiency; 4) contract requirements, HEDIS measures, and NCQA standards; and 5) PsychHub, which gives expanded capability of education and resources to providers. Many trainings offer the opportunity to earn continuing medical education (CME) credits.
- **Cultural Competency.** Providers are key allies in reducing health disparities, so we offer cultural competency training on demand through our provider website, promoted through our orientation program; in monthly newsletters; and through our provider handbook. We have invested in a suite of provider trainings on MyDiversePatients.com that are linked through our provider portal. The range of training topics includes addressing racial and ethnic disparities in asthma care, creating an LGBTQ-friendly practice, reducing health care stereotypes, and increasing breast cancer screening for Black women. Many of these courses include free CME credit.
- **Pharmacy-related Reports in the PCMS Portal.** This information includes member-specific alerts, such as controlled substance prescription drug use, as well as member information regarding nonadherence to key classes of medications, allowing focus and quick action by providers. Our Nebraska CDTs incorporate this data into their work with providers, with support from our Pharmacy Director, who routinely meets with CDTs to discuss pharmacy changes.
- **Opioid Prescriber Management Program.** This program, managed by our affiliated PBM, assesses physician opioid prescribing patterns against several utilization metrics, such as the percentage of members who are newly prescribed opioids. An Opioid Prescribing Summary report details providers' opioid prescribing patterns against evidence-based quality standards and peer comparisons. We share this information to highlight opportunities and provide support to improve prescribing practices.
- **Project ECHO®.** Project ECHO helps the collaboration of physical health and BH services through telehealth and provides provider education and care coordination that support providers, using evidence-based guidelines and tools to identify and treat opioid use disorder. We are collaborating with University of Nebraska Medical Center (UNMC) to bring support to rural family medicine providers.

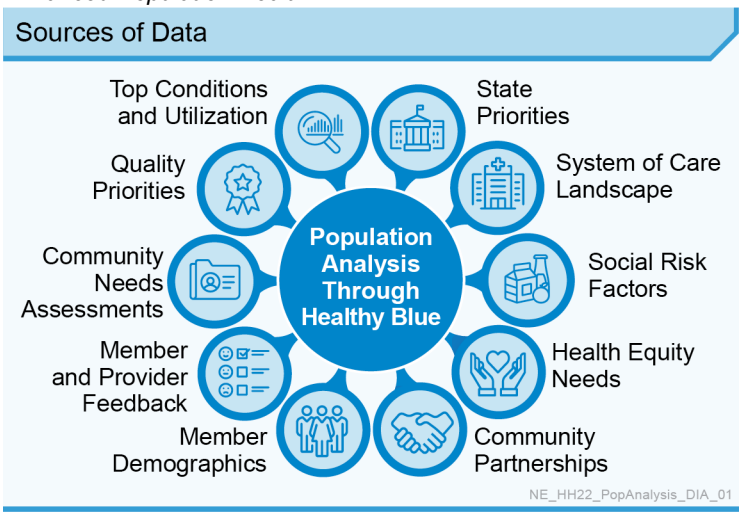
Focus Area Selection

Healthy Blue aligns its goals with the Nebraska State Quality Strategy and analyzes available internal and external data to identify focus areas. Data sources include, at a minimum: claims and encounters, authorizations, call center statistics, appeals and grievances, medical record reviews, care plans, HEDIS measures, CAHPS measures, case management audits, and provider satisfaction surveys. Sources of data are depicted in Figure V.M.64-6. In addition, Healthy Blue collects data from the census, environmental, economic, social, and clinical/health care for the community to identify and reduce racial and ethnic health disparities in clinical areas. Healthy Blue's core mission is to provide high-quality care that improves our members' well-being and enhances population health outcomes for the communities we serve.

Driven at the leadership level, we leverage every part of our organization to improve quality outcomes. Implementing interventions to successfully address these issues is an organization-wide effort to align our resources across all domains. Our proven QI framework focuses on the development of innovative solutions to address member needs and bring services to members within their communities. This framework includes:

- **Analyzing Internal and External Data.** We researched, cataloged, and analyzed health trends and priorities identified by Nebraska Governor Pete Ricketts, DHHS, Nebraska Medicaid Enterprise, and the Nebraska Department of Public Health.
- **Identifying Health Equity and Population Health Goals.** By integrating data sets to identify priorities and opportunities, we can establish baselines, target improvements, and measurable goals.
- **Engaging Community Organizations and Stakeholders.** We listen to our local partners to adjust our priorities and develop initiatives that meet the needs of the communities we serve. This includes securing specific feedback through workgroups like our Member Advisory Committee, which has already convened to provide specific insight.

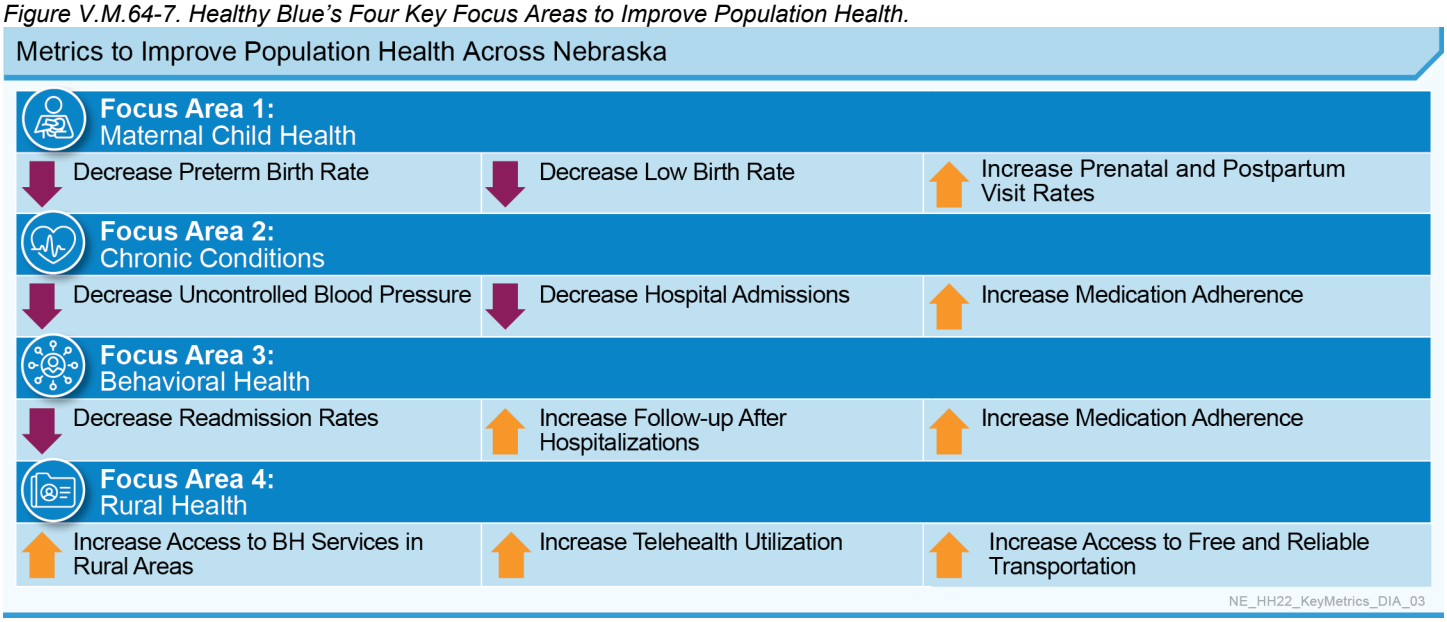
Figure V.M.64-6. Healthy Blue Leverages Multiple Data Sources to Enhanced Population Health.



- **Implementing Targeted Interventions to Improve Health Outcomes.** We collaborate across our organization to design and implement initiatives, including everything from wellness initiatives to care management interventions for those with the most complex clinical needs.
- **Monitoring and Evaluating Progress.** We continuously monitor our initiatives, track outcomes, and modify our programs as needed.

Using this approach, Healthy Blue has identified health priorities that align with MLTC's goals and the State's quality strategy and has identified opportunities for improvement based on internal and external data and trends. These areas include: 1) Chronic Conditions: Hypertension and Diabetes; 2) Maternal Child Health: Low Birth Weight and Preterm Birth; 3) BH Needs: Readmission and Follow-up; and 4) Rural Health: Access and Transportation. Figure V.M.64-7 provides an example of our framework in action with identified key performance indicators.

Figure V.M.64-7. Healthy Blue's Four Key Focus Areas to Improve Population Health.



QAPI Work Plan

Our QAPI work plan provides a blueprint for the upcoming year and documents our goals and objectives, scope of activities, timelines, processes, systems, and strategies for assessing and improving the quality of care and services. The work plan, which meets all NCQA and HEDIS standards for reporting and measurement, includes a set of domains that span the entire health plan. The domains and subdomains include:

- QM program structure, continuity, and coordination of medical care as well as continuity and coordination between medical care and BH care
- Population health management (PHM) and health equity strategy, population identification and assessment, delivery system support, and PHM impact
- Network management, availability of practitioners, accessibility of services, assessment of network adequacy, and directory maintenance and updates
- UM program structure, timeliness of UM decisions, and appeals
- Credentialing and recredentialing
- Monitoring ongoing interventions
- Member rights, responsibilities, and experience
- HEDIS and CAHPS measures and interventions

The performance measures are evaluated throughout the year, and target dates for implementation and completion of all phases of Healthy Blue's QAPI activities, consistent with the clinical quality performance measures and targets set by the State agency, include, but are not limited to:

- Data collection and analysis
- Evaluation and reporting of findings
- All collected data must be available to Healthy Blue and MLTC
- This information must be submitted for review and approval by MLTC prior to distribution
- May include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews
- Implementation of improvement actions, where applicable
- Individual accountability for each activity

Work plan activities align with contractual, accreditation, or regulatory requirements and identify activities, specific time frames, responsible staff, and measurements to accomplish goals, including those identified as the key focus areas by the MLTC's Quality Strategy. Figure V.M.64-8 shows a high-level list of activities included in the work plan.

The work plan specifies measures within each domain, performance targets (often NCQA's 75th or 90th percentile for HEDIS), interventions, responsible staff, implementation dates, incentive amounts, and committee reporting time frames.

Figure V.M.64-8. Healthy Blue's QAPI Initiatives Support MLTC's Quality Strategy.

Healthy Blue Activities

QAPI Activity	Frequency	Deliverable
Measure and Report on Quality Performance	Annually	Program Evaluation and Plan for new and improved activities
Operate Comprehensive QAPI Program	Annually	QAPI Program Description, Work Plan, and Provider Support Plan
Evaluate QAPI and CLAS Program	Annually	QAPI and CLAS Program Evaluation
QAPIC and Subcommittee Meetings	Quarterly	Signed and dated minutes
HEDIS© Measurement	Annually	Audited HEDIS results, stratified by population
CAHPS Survey	Annually	Results of CAHPS Survey
Administrative Encounter Data	Weekly	Reconciliation and review of source data to assure accuracy
Performance Improvement Projects	Ongoing	Proposal before initiation, status measurement, and final report
Maintain NCQA Accreditation	Ongoing	Accreditation Report, status, and ongoing monitoring

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Our 2021 work plan priorities were influenced by our QM program evaluation and include enhancing live outreach to boost our member engagement rates. After completing our detailed data analyses, we identified barriers to member engagement, including communication preferences, day of the week and time outreach occurred, and the level of effort tied to member clinical acuity. We recently enhanced our multimodal member outreach and engagement strategy to be aligned with our member risk stratification for all Healthy Blue members. This strategy continues to grow and evolve as we apply our continuous improvement framework to our new approach. One of our initial actions was to reorganize and reallocate resources and to streamline outreach into a more efficient and effective model. The outreach continuum focuses on not leaving any member behind, so contact intensifies as members are identified who need that greater intensity of outreach. Our strategy and planned initiatives include what is outlined in Figure V.M.64-9. Additionally, we plan to perform data-driven and targeted interventions throughout the state with community partnerships and providers. For example, we will be implementing a Supportive Pregnancy Care program with the March of Dimes, which follows an evidence-based group care model that will be implemented in Douglas County. We will also be partnering with Blue Cross Blue Shield for our mobile mammogram initiative. Due to limited access for mobile screenings in metro areas, we will focus on partnering with an independent imagining center statewide.

Work Plan Activities to Reduce Disparities. As we intensify efforts to improve health equity in Nebraska, our work plan will continue to include initiatives to reduce or eliminate health disparities among members. Our ***Health Equity Director, Tiffany White-Welchen, LIMHP***, will work closely with our Whole Health Director, QM Coordinator, and clinical teams to drive the strategic vision of embedding health equity in all aspects of plan operations. In addition, Healthy Blue will make sure that our health equity efforts are aligned to the following goals:

- Assuring member satisfaction by delivering a patient-centered approach that incorporates the perspective of members and their families into all aspects of their care
- Driving health outcomes through preventive screenings, appropriate service utilization, and integrated care
- Integrating with providers by incorporating provider insights into our approach, fostering a collaborative approach to care, and reducing administrative effort
- Grounded in the community by addressing local health priorities through capacity building, implementation, and ongoing evaluation of programs with community partners, with a focus on reducing health disparities

CALLED TO CARE
Tiffany White-Welchen, Health Equity Director

A Nebraska native, I've served Medicaid patients for over 20 years, worked as a Medicaid mental health practitioner for more than 15 years, worked in community mental health for 8 years, and been part of a managed care organization for more than 3 years. My career is more than a job - it's a mission to make a difference in the lives of vulnerable people who need help to navigate the health care system.

CALLED TO CARE: Being able to assist in breaking down barriers, removing health inequities and advocating for Medicaid members is very fulfilling. My parents taught me the importance of not just giving back to the community, but being part of the community. I have a very strong passion for underserved and vulnerable populations and want to continue to assist in educating community members about chronic health conditions, maternal health, and behavioral health. Working together, we can achieve long lasting positive change.

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- Providing a comprehensive strategy that aligns with MLTC to drive efficiency, avoid duplication of resources, and identify synergies
- Delivering cost savings through cost-effective, evidence-based, sustainable interventions that deliver the right care at the right time in the right place

No. 65

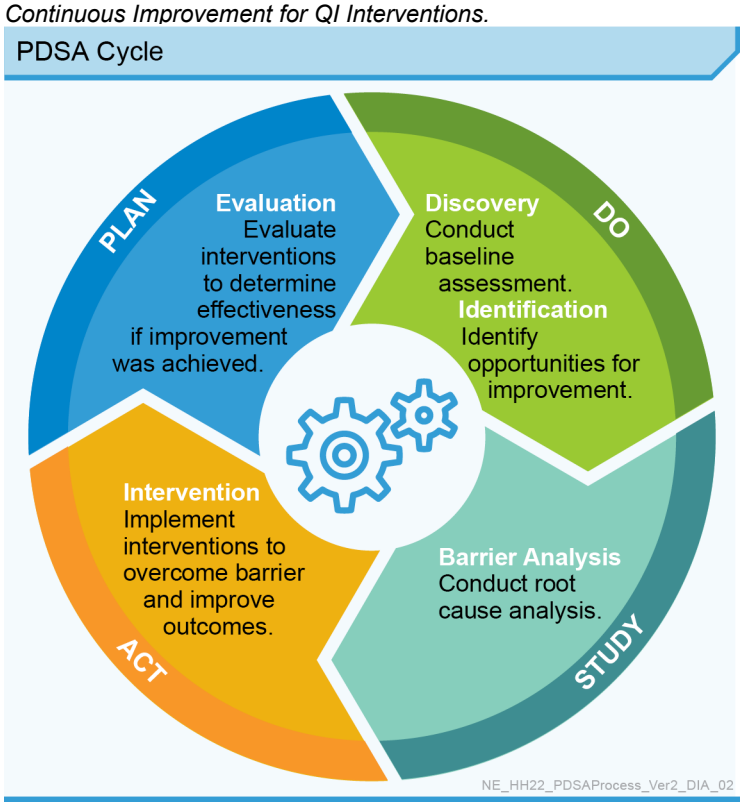
Quality Improvement Interventions over Time

Healthy Blue's organizational mission is rooted in quality improvement (QI) and continuously prioritized in our workplace culture and at the heart of everything we do. Every employee at Healthy Blue is a quality champion, practicing continuous quality improvement (CQI). Our Quality Assessment and Performance Improvement (QAPI) process, executed by our Quality Management team, is NCQA aligned, compliant with MLTC, and intertwined with our population health philosophy. Our QAPI program measures the success of interventions from initiation through implementation. We identify health outcome trends in need of improvement, specific subpopulations most affected by disparate health outcomes, and key determinants impacting health among those subpopulations. Further, we measure and track the outcomes of individual QI interventions over time to meet MLTC's quadruple aim goals and continuously improve outcomes for Nebraskans. Healthy Blue's approach to measuring and tracking the outcomes of individual QI interventions over time is described.

Measurement and Tracking Outcomes of QI Interventions over Time

Healthy Blue applies the Plan-Do-Study-Act (PDSA) method, illustrated in Figure V.M.65-1, for measuring and tracking the outcomes of our QI interventions over time. Our PDSA approach includes the review and analysis of multiple indicators of quality of care and service against benchmarks for quality clinical care and service delivery. When variations are noted, we conduct a root cause analysis and develop detailed action plans to address the variations. We re-measure improvements over time to assure continuous progress toward our established goals.

Figure V.M.65-1. Our Plan-Do-Study-Act Process Assures Continuous Improvement for QI Interventions.



A Data-Driven Approach

Healthy Blue develops and implements quality initiatives and process improvements driven by data analysis. We conduct data analytics to establish a baseline in the planning stages for each QI project, which helps to define the scope of the program and confirm that appropriate goals and objectives are set. Additionally, we continue to use data throughout subsequent project execution to identify necessary adjustments to our defined interventions and make real-time adjustments to achieve the desired outcomes. Following intervention implementation, our analytics team works with the program to assure data collection and ongoing performance measurement by summarizing performance, trends, disparities, and outliers. We use data analytics to determine any differences between the stated goals and the program results as part of our program evaluation.

Our QAPI Committee and subcommittees reassess initiatives monthly during our interdepartmental HEDIS® Taskforce meetings. They also perform more formal evaluations quarterly and annually to evaluate intervention effectiveness and compare year-to-year performance through our committee structure and QAPI Evaluation. Healthy Blue collects, aggregates, and analyzes data from multiple internal and external sources to transform and evaluate the effectiveness of our QAPI program, and we report on our program success to MLTC as required.

Data Sources

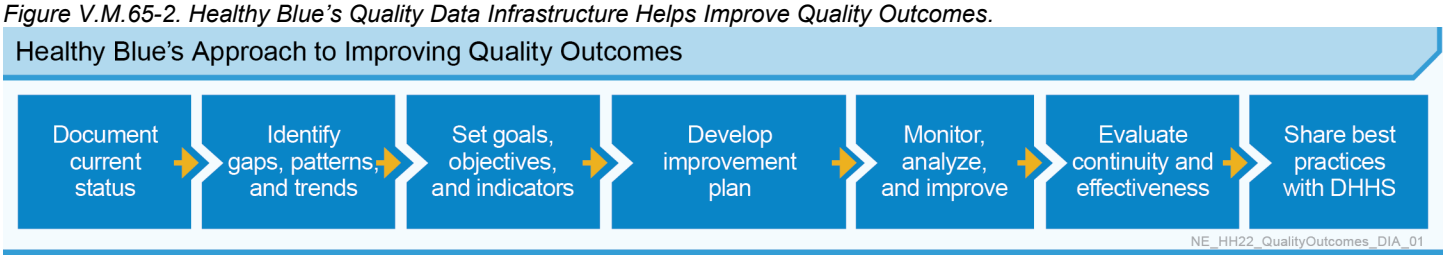
We use a combination of administrative, survey, and medical record data, internally collected or provided by our subcontractor partners or public data sources, to help us identify opportunities for improvement, disparities, and effectiveness. Additional data sets include enrollment information; Health Information Exchange (HIE) data; Electronic Medical Record (EMR) data from providers; claims; encounters; authorizations; appeals; complaints; care management documentation; access and availability survey findings; member medical records within provider offices and facilities; immunization registry information; surveys by external bodies, such as accreditation entities or CMS; QI studies; State data files; CAHPS® surveys; and HEDIS results.

Data Collection Methodology and Sampling

We aggregate actionable data in our Health Intech analytics platform and leverage our quality analytics capabilities and our HEDIS data warehouse to generate comprehensive reports on utilization, clinical indicators, and trended, segmented, and comparable data from this robust quality data infrastructure. These reports provide information on access to care, demand for services, and quality of services delivered to our members. They include encounter data, lab results, and immunizations along with electronic health record and HIE data. The data warehouse performs advanced data analytics, including predictive modeling; identifies members for care management (CM); and supports operational, management, regulatory, and ad hoc reporting.

Our QAPI program leverages our data reporting and analytics capabilities. We generate information on utilization, clinical indicators, and trended, segmented, and comparable data from this robust quality data infrastructure. We use data to report information on the success of our interventions and to support the CQI process. Figure V.M.65-2 shows our approach.

Figure V.M.65-2. Healthy Blue's Quality Data Infrastructure Helps Improve Quality Outcomes.



We select samples based on the indicator or measure to be evaluated and document this detail in our program materials. Sampling is statistically valid and is used for data collection when appropriate, including as indicated in HEDIS specifications. Additionally, we determine sample size to select a target variance derived from the obtained sample. For example, when data is collected for our Performance Improvement Plans (PIPs), we determine if the random statistically significant sample has a confidence interval of 95% or -5.

Data Collection Frequency and Analysis

We collect data continuously and at systematically specified intervals, such as daily, weekly, monthly, quarterly, and annually. Data collection and reporting frequency is included in the Quality Management Work Plan for each measure or activity. Data results are reported on a comprehensive dashboard, and our Quality Management team presents to the relevant QAPI Committee, subcommittee, or taskforce for review and analysis.

We conduct quantitative and qualitative analyses to evaluate the effectiveness of our individual QI interventions and our analyses include identifying potential barriers for achieving desired outcomes and interventions or recommended strategies. Over time our Quality Management team completes the analysis and evaluation to determine the effectiveness of each intervention.

Healthy Blue Follows the Institute for Healthcare Improvement Process

The Institute for Healthcare Improvement has established a process that includes six essential practices for sustained improvement. This gold standard consists of:

- Standardization of the procedures, meaning consistency of procedure for all staff, every time, with the common focus of patient welfare.
- Accountability is the process by which standard work is reviewed, a resolve for excellence.
- Visual management using clear, simple data displays at the unit level, reviewed daily, which show performance on key quality measures over time and track problems the team is currently addressing.
- Problem solving for improvement so that staff can address issues as they arise, including a forum for raising and triaging quality problems, disposing of simple ones, and providing the means to escalate more complex problems.
- A standard escalation process for problems that frontline staff cannot solve immediately and may require interdepartmental coordination.
- Integration and active communication with consistency of purpose and mission between levels of management and professional staff, and across departments. This requires an infrastructure for quality assurance and QI and taking an active, daily role in promoting quality and consistency. We also use a process for escalating the goal and modifying the intervention for continuous improvement over time.

Our Performance

Healthy Blue's success in implementing and tracking PIPs is evidence that we excel in measuring and tracking interventions over time, which leads to QI. We address all PIPs in our annual QAPI Program Description, Work Plan, and Program Evaluation, and we report the status and results of each project to the State as outlined in the Quality Strategy. Healthy Blue assures that all PIPs comply with CMS requirements and tracks them year over year. Additionally, our Quality Management team delivers PIP status regularly to the Quality Assessment and Performance Improvement Committee and subcommittees, such as the Health Equity Committee, for oversight. Figure V.M.65-3 highlights how our dedicated and targeted efforts have led to year-over-year improvement in several behavioral health (BH) HEDIS measures.

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Examples of Successful Healthy Blue QI Interventions

[redacted]

[redacted]

No. 66

Performance Measures to Drive Improvements and Positively Affect the Health Care Status of Members

Healthy Blue takes a data-driven approach to quality, using performance measures, survey data, and other metrics to set the baseline and performance targets of our Quality Assessment and Performance Improvement (QAPI) program. The scientific method of continuous quality improvement (CQI) requires measurement and remeasurement at regular, predefined intervals. Our Quality Management team routinely monitors and analyzes our HEDIS® and key performance measures on a biweekly, monthly, quarterly, and annual basis. Additionally, data is analyzed against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. These performance rates are used to develop and monitor tailored interventions to support providers and engage members. We also routinely use the CAHPS® survey and Provider Satisfaction Survey to analyze annual member and provider experience with clinical care and services. We also use this data to compare performance against national benchmarks and State performance goals to identify improvement opportunities and take action.

In addition to analyzing our own performance measures, Healthy Blue collects and uses a wide range of member-, provider-, and community-level data (as shown in Figure V.M.66-1) to inform our QAPI program initiatives and population health strategies. We leverage our enhanced data capabilities to then design initiatives to improve member outcomes, member experience, and provider satisfaction.

Our local and well-qualified Quality Management (QM) team is dedicated to managing and overseeing the performance measurement process. Healthy Blue has a dedicated HEDIS Administrator who is responsible for collecting and analyzing data for QM on member and provider outcomes, including disparities data, care gaps, social determinants of health (SDOH) data, claims analysis, EPSDT services, well-baby and well-Child assessments, immunization services, and grievances and appeals data. The HEDIS Administrator works collaboratively and cross-functionally with all areas within the health plan to address quality issues.

In addition to the work done locally, Healthy Blue also leverages our organization's national Medicaid division's enterprise data warehouse to support operational processes, analytics, and reporting. Our HEDIS administration process establishes an overview of our methods of data collection, quality control, and QM practices in defining administrative, hybrid, and survey data. Performance goals include MLTC goals, NCQA goals, accreditation, and federal guidelines. Data amassed from these efforts is imported into the HEDIS warehouse, proofed, and pulled into the certified software vendor warehouse. Audited data is used in administrative measures, for medical record projects, and for CAHPS sample generation. We have a data quality control process in which data is evaluated prior to and after each system update. Additionally, we have a data extraction and quality control process for external data extraction.

This real-time data warehouse receives data directly from many original sources to promote quality, control, and consistency. It creates the flexibility needed to support rapid development and deployment of new data exchanges through secure data transfer. Healthy Blue leverages a variety of tools for internal monitoring to incorporate, trend, and act on data within our QM program, as shown in Figure V.M.66-1.

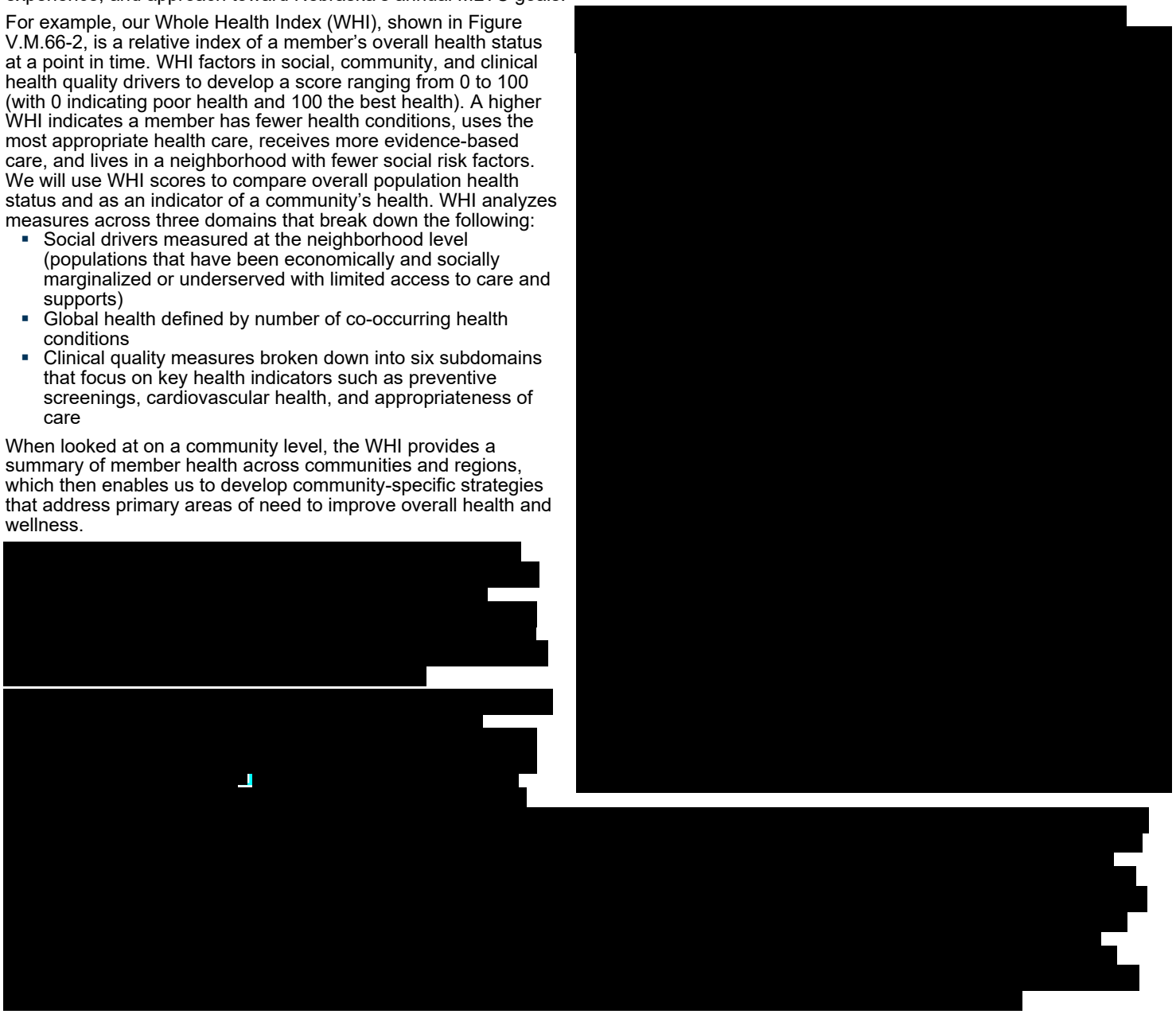
By tracking performance measures and other data, we identify gaps in care and opportunities for improvement. We have expertise and processes in place to integrate disparate data sets with our member and provider data, including combining race, ethnicity, and cultural information to identify vulnerable populations and emerging trends. We use county-level data to direct our focus areas and interventions. We leverage internal workgroups, such as the HEDIS Taskforce and Performance Improvement Project (PIP) workgroup, to discuss performance data, identify opportunities for improvement, and ideate cross-functionally on targeted interventions to improve outcomes.

With every quality improvement (QI) effort we implement, we capture and evaluate data that demonstrates our technical qualifications, experience, and approach toward Nebraska's annual MLTC goals.

For example, our Whole Health Index (WHI), shown in Figure V.M.66-2, is a relative index of a member's overall health status at a point in time. WHI factors in social, community, and clinical health quality drivers to develop a score ranging from 0 to 100 (with 0 indicating poor health and 100 the best health). A higher WHI indicates a member has fewer health conditions, uses the most appropriate health care, receives more evidence-based care, and lives in a neighborhood with fewer social risk factors. We will use WHI scores to compare overall population health status and as an indicator of a community's health. WHI analyzes measures across three domains that break down the following:

- Social drivers measured at the neighborhood level (populations that have been economically and socially marginalized or underserved with limited access to care and supports)
- Global health defined by number of co-occurring health conditions
- Clinical quality measures broken down into six subdomains that focus on key health indicators such as preventive screenings, cardiovascular health, and appropriateness of care

When looked at on a community level, the WHI provides a summary of member health across communities and regions, which then enables us to develop community-specific strategies that address primary areas of need to improve overall health and wellness.



Identifying, Tracking, and Improving Quality Performance and Member Outcomes

We identify, track, and improve system performance through our data-driven QI approach. Our Quality team leads and works cross-functionally to continuously evaluate our quality data, membership and its characteristics, utilization patterns, and year-over-year performance measures to identify and implement interventions. Through data analysis and ongoing evaluation, we identify low-performing measures in which we implement targeted interventions and quality initiatives to improve outcomes. Figure V.M.66-2 shows improvement in member outcomes and HEDIS rates over time and the associated quality initiatives. Additionally, we align our concentrated effort with State goals and priorities as outlined in the MTLC Quality Strategy, and we take the State's Quality Payment Plan (QPP) measures into consideration. We have implemented enhanced initiatives broadly across our member and provider space to improve outcomes. These initiatives included adding and enhancing member and provider education and communication. We have leveraged technology to make educational materials easier to access and to increase communication speed for both members and providers. We also invested in a robust telehealth strategy that was critical during the pandemic. We also revamped our Healthy

Rewards member incentive programs. Figure V.M.66-3 shows QI initiatives that we have implemented that led to year-over-year performance improvement.

Performance Measurement Data in Action: Changes Implemented to Improve the Program and Members' Health Outcomes

Our targeted focus on following up with members who had been to the hospital for mental illness or substance use led to relationship building with three of the state's largest behavioral health hospitals (Immanuel, Lasting Hope, Bryan Health). Inpatient member outreach and the CyncHealth Data feed established allows for timelier member outreach. Additionally, we have live outreach calls based on claims data and available EMR/ADT feeds. We call members to help them schedule follow-up appointments, arrange transportation, and identify if they have any other needs. The pandemic amplified our need to get members access to care wherever they are and at the time they need it. We have adopted telehealth strategies, including LiveHealth Online, to assure members can get care at the right time and in the right place.

We have taken action based on performance measures and feedback and implemented changes to improve the provider's experience. One example of this is establishing an internal provider workgroup, which is a forum allowing senior leadership and functional area leaders to identify improvement opportunities. Two examples of changes implemented based on provider surveys from this forum was a change to provider rosters and enrollment. We also implemented a member workgroup to assure that all member-facing departments are informed and collaborating on improvement initiatives to better serve our members.

Healthy Blue is committed to using results of performance measures, provider feedback, member feedback, and other data to drive improvements. We recognize that we need to focus on health disparities and improving health equity for all Nebraskans. To do this, we have enhanced our data capabilities and completed a deep-dive analysis to formulate our population health strategy. In Figure V.M.66-4 we identified a key priority, baseline measure; developed SMART goals; identified key performance indicators; implemented high-level strategies; and then developed interventions to improve outcomes and health equity.

[redacted]

No. 67

Assessing Quality and Appropriateness of Care

Healthy Blue has a multipronged approach to assess the quality and appropriateness of care for all members, including members with Special Health Care Needs (SHCN), members with co-occurring physical health (PH) and behavioral health (BH) concerns, and dual-eligible members. Our goal of improving member health and well-being requires that we consider all needs, especially for those members with complex care needs. We identify all members including members with co-occurring PH and BH concerns, and dual-eligible members through the State 834 enrollment file. As we work with individuals and caregivers, our member outreach and clinical staff perform retrospective reviews of secondary claims, as they are indicators of additional coverage. By reviewing secondary claims, we are able to further identify individuals who have co-occurring PH and BH concerns and dual-eligible members.

Our processes, policies and procedures, and day-to-day operations are fully compliant with the SOW. Cross-functionally, we track and trend data such as claims data and utilization management (UM) data to make sure we have line of sight into the quality and appropriateness of care. All of this data is reported out through our Quality Assessment and Performance Improvement Committee (QAPIC) structure, in which health plan leadership participates. This data is part of our annual evaluation, and we track data daily, weekly, monthly, quarterly, and annually to be able to analyze trends and implement solutions when needed. Healthy Blue assesses the quality and appropriateness of care furnished to members including SHCN, members with co-occurring PH and BH concerns, and dual-eligible members through the ways presented in Table V.M.67-1.

Table V.M.67-1. Healthy Blue's Methods for Assessing Appropriateness of Care.

Grievance and Appeals Data	Our Quality department works cross-functionally to track and collect grievances and appeals data. We retain information on general descriptions of the reason for each grievance and appeal; the date received; date of each review, including review meetings; resolution at each level; and the name of the member for whom the grievance and appeal was filed. We also aggregate this data so we can do trend analysis on number received, the type and name of provider, descriptions, timeliness of resolution, and outcome. This data is reported out quarterly in our Quality Committee structure and annually for a formal evaluation.
Quality of Care Investigations	Our Chief Medical Officer, Dr. Esser, determines if there is a significant quality issue by segmenting incidents via differentiation between a "substantiated" or "unsubstantiated" and "adverse" or "non-adverse" finding, depending on whether there is evidence of a deviation from the standard of care and classification in one of the quality of care concerns classification categories. When a quality issue is identified, the Medical Director takes appropriate actions, including, but not limited to, letters requesting clarification, external peer review, and credentialing, and we closely track this data to identify trends. These trends are reported up to the Clinical Advisory Committee, and the QAPIC has oversight of this process.
Health Risk Screening (HRS)	All members are screened using an HRS and members at higher risk are also provided a Health Risk Assessment (HRA). The HRA is a more detailed assessment for those members who have been deemed to potentially qualify for care management services. The HRA is used to collect information on a member's health status that includes, but is not limited to, member demographics, personal and family medical history, and lifestyle. Members with needs identified are offered warm hand-off to a local, licensed Care Manager to create the care plan and begin work toward member goals, meeting needs, and improving overall whole person health care. Our Care Managers work closely with community agencies and local resources for seamless referral and ongoing follow-up.
Concurrent Review Process	Our UM department tracks appropriateness of care on every initial and concurrent review. Concerns/updates are shared during daily during UM rounds with the Chief Medical Officer.This process evaluates the ongoing needs of our members and assesses the appropriateness of the setting and level of care. Our reviewers take into consideration the comprehensive needs of each member, make sure that all needs are being met, and if not, make certain that collaborative efforts are being made with the hospital medical professionals. If BH needs are identified, we refer to our internal BH Case Managers and also discuss this member at clinical rounds. If needed, we reach out to hospital case managers in a collaborative effort to assure that this member's needs are known and addressed.
Peer to Peer Process	Our Restricted Services program identifies members for review based on prescription drug patterns. Each member is reviewed in depth by our Medical, BH, Pharmacy, and Care Management teams. In addtion to determining Restricted Services status, providers are also contacted personally regarding prescribing concerns, and members are referred for care management when indicated.
Weekly Rounds	The PH and BH Care Management and PH and BH UM team meet weekly to present challenges and work together to make sure member needs are met. UM can refer members to care management during the weekly meeting or via care management email. The Care Management team is able to outreach to UM or present cases during this weekly team meeting if UM needs arise. The team works together to find creative solutions to assure our members' needs are met.
Provider Monitoring	Healthy Blue's BH team has a quality initiative in which outpatient BH providers are audited for quality reviews. One of the items reviewed is whether providers are seeking communication with the PCP regarding the member. If this is not in the record, individual provider education is

	given to make sure this takes place in the future. Healthy Blue is dedicated to serving Nebraskans through a fully integrated care model that includes our population health and quality strategies, consistent collaboration with providers, established clinical systems, and policies and procedures that combine to contribute to the improved health of our members.

Identification of Members

Healthy Blue identifies members including those with SHCN and dual eligibility within 90 days of receiving the member's historical claims data (if available). MLTC may also identify members needing specialized health care and provide that information to Healthy Blue. A Licensed Mental Health Professional (LMHP) or the PCP can also identify members as having specialized needs at any time the member presents seeking care. If eligible, we work with members to develop an individualized treatment plan with the treating provider and a patient-centered care plan is developed with the member, their Healthy Blue Care Manager, and any participant the member chooses. This is completed within 30 days and in compliance with applicable quality assurance and UM standards. It is reviewed as frequently as needed, when requested by the member or provider or following a significant change in circumstances, but at a minimum, annually. Additionally, Healthy Blue has a process to identify dual-eligible members in compliance with CMS requirements for Dual Special Needs Plans. Our approach minimizes duplication of effort associated with multiple assessments and related member contacts by using any Medicare payer information that may have been previously collected, closing any information gaps to assure a comprehensive patient-centered care plan is in place, and establishing a collaborative care management framework that features transparency and communication between Care Managers to assure the best possible health outcomes for the member. Healthy Blue accesses electronic data of participating Medicaid providers and accesses provider updates to define the services and products for which dual-eligible individuals qualify. Healthy Blue receives electronic data containing Medicaid network providers monthly.

Additionally, Healthy Blue utilizes a comprehensive HEDIS Data Warehouse certified NCQA to run HEDIS performance rates in which we are able segment rates by unique member diagnosis or dual-eligible designation. This process allows us to determine significant care gaps by populations to develop tailored interventions to improve the quality and appropriateness of care received. Examples of metrics tracked include Follow-up After Behavioral Health Hospitalization and Patient Engagement After Inpatient Discharge.

Strong Care Coordination and Integration Drives Quality and Appropriateness of Care

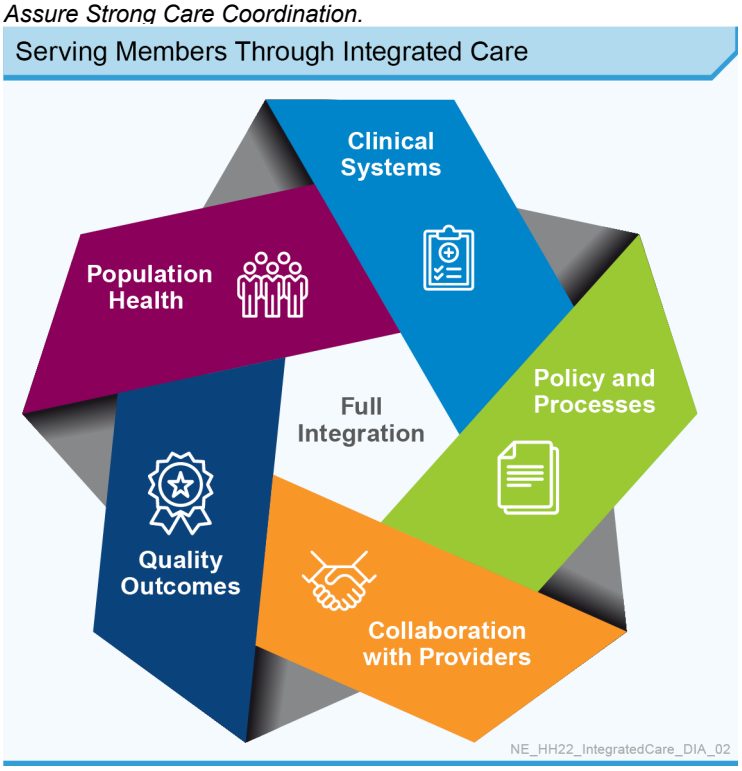
Our care management model (shown in Figure V.M.67-1) features the same intensity of care management and coordination — only the operational details differ as warranted by payer type. During the care coordination or UM process, our Care Managers and UM staff will monitor the authorization of services to make sure the correct payer source is identified and engaged appropriately in each instance. Part of these activities may include:

- Coordinating with Medicare and the State as needed
- Working with Members to connect with their Medicaid PCPs, if different than their Medicare provider, to access covered services through a contracted provider
- Supporting access to Medicaid covered providers that are not covered under Medicare, such as LMHPs
- Connecting to community service and support providers as dictated by a member's need
- Monitoring by Case Managers for dual members under our Care Transitions Intervention (CTI®) program. Those members are identified, and outreach is completed by our Care Managers, who oversee this program

We use appropriate health care professionals to determine the quality and appropriateness of care for members, including those with SHCN. Additionally, our patient-centered care plan includes things important to the member such as goals for healthier living, exercise, employment, and social engagement. Ongoing quality of care monitoring is performed as a part of the patient safety initiative to assure the quality of care issues are received and investigated, outcomes are assessed, and corrective action plans are implemented, as needed.

We clearly define the roles and responsibilities for coordination and communication between the BH Care Managers, Health Plan BH Case Managers, Population Health Care Managers, and BH Case Managers. Coordination and communication between Case Managers and Care Managers will prevent duplication of services and assure that members receive cost-effective, quality care in the most appropriate setting.

Figure V.M.67-1. Healthy Blue Leverages Multiple Channels to Assure Strong Care Coordination.



One of the challenges for members with co-occurring conditions is that there are separate protocols and staff with defined roles on both the PH and the BH side. Responsibility for precertification, concurrent review, and case management are different between PH and BH. Therefore, we have established hand-offs and protocols to clearly define the coordination of care and service for these members. For members with co-occurring PH and BH conditions, our BH Case Managers coordinate case management services with PH Case Managers and/or Care Coordinators. These functions are separate to assure optimal coordination of care for members. We recognize

that when members have co-occurring PH and BH conditions, coordination of care, including case management and Disease Management services, is essential if optimal positive health outcomes are to be achieved.

Healthy Blue has a deep understanding that members who have co-occurring PH and BH conditions need appropriate coordination to improve the quality of their care and the overall response to treatment. Members with co-occurring PH and BH conditions are at risk for increased hospitalizations and increased cost of care. Healthy Blue has developed evidence-based utilization review criteria to guide both providers and concurrent reviewers to the most appropriate level of care. We minimize prior authorization requirements for most outpatient, community-based services for BH and comorbid conditions. Healthy Blue continually monitors best practices and improvements in the management of co-occurring conditions and regularly modifies clinical criteria and guidelines to reflect these changes. Through systematic data collection and analysis, opportunities for improvement are identified and activities are undertaken to improve the continuity and coordination of medical and BH care for members.

Our departments work together to share relevant member information, and we also facilitate the sharing of information between PCPs and BH providers. Maintenance of documentation of care coordination is done in the member's electronic medical record in our care management system, Health Intech. To maintain sufficient oversight, we facilitate internal audits. The UM reviews are internally audited monthly. A random sample of files are selected and reviewed for quality and appropriateness of care.

When there are co-occurring PH and BH conditions, appropriate clinical staff collaborates with providers to assure coordination of all necessary care is based on the needs of the member. Care coordination and complex case management (CCM) of SHCN populations is part of a comprehensive care management program that offers a continuum of services including CCM, care coordination, chronic care management, and UM. The assigned Care Manager collaborates with the Care Coordinator or other member designee in the special population program.

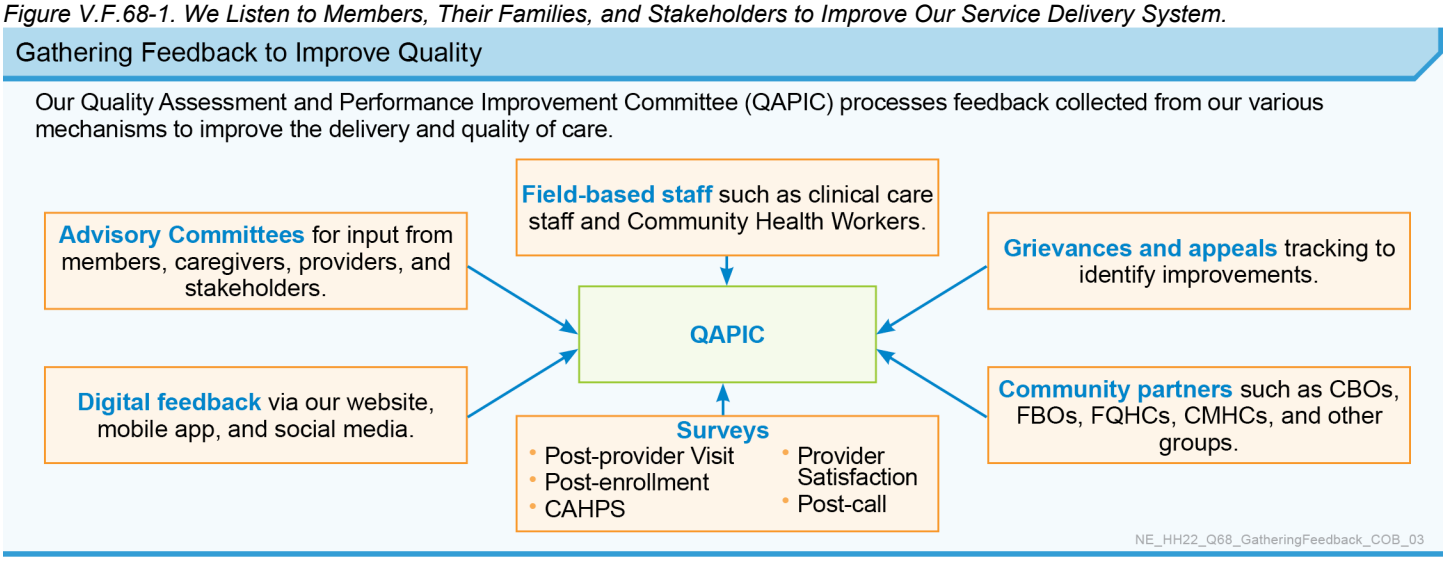
When a PH or BH provider recognizes a need for treatment for a co-occurring PH or BH condition, the provider may use the provider toll-free telephone line for consultation and/or assistance with referrals for coordinating care. To encourage coordination between providers, BH providers have access to a coordination form to alert PH practitioners when a member enters treatment. Providers can access the form on the provider website.

No. 68

Mechanisms We Use to Solicit Feedback and Improve Quality of Care

At Healthy Blue, we believe that every interaction with members is an opportunity to collect feedback and improve our services. We offer all members and stakeholders, including older adults, members with disabilities, and those needing vision or hearing accommodations, opportunities to provide feedback in multiple formats and venues. We listen to members, providers, community partners, MLTC, and other State agencies and act on their recommendations to continually improve the delivery of services and quality of care. Our ***Quality Assessment and Performance Improvement Committee*** (QAPIC) is responsible for using feedback collected from advisory committees, surveys, in-person touchpoints, digital mechanisms, and other sources (community engagements, care coordination, events) to identify and implement programs that result in improved service delivery and health outcomes as part of our continuous quality improvement process (see Figure V.F.68-1).

Figure V.F.68-1. We Listen to Members, Their Families, and Stakeholders to Improve Our Service Delivery System.



Advisory Committees

We have supported a ***Member Advisory Committee*** (MAC) and ***Provider Advisory Committee*** (PAC) since beginning operations in Nebraska. Overseen by QAPIC, the MAC serves as a structured, interactive forum for us to listen to member and stakeholder feedback and recommendations about the delivery of services, quality improvement activities, program monitoring and evaluation, and member, family, and provider education. The MAC offers input regarding education and outreach programs, health literacy campaigns, and makes sure our grievance and appeal resolution processes are culturally and linguistically sensitive, as well as easy to access and understand. Our ***Member Experience Workgroup***, an internal advisory group comprised of cross-departmental staff, meets monthly to discuss member experience successes and areas for improvement and funnel information to QAPIC for further review and action.

Field-based Staff

Our field-based staff solicit feedback through their interactions with members and make sure it gets to the QAPIC to appropriately assess and address. [redacted]

Collaboration with Community Partners

We leverage relationships with our partners, including community-based organizations (CBOs), faith-based organizations, health departments, Federally Qualified Health Centers, mental health centers, homeless shelters, food banks, and governmental agencies, to better understand the communities we serve, co-host events, and provide on-site member education. [redacted]

Digital and Social Media

In addition to establishing a physical presence in communities and collecting feedback through surveys, we use our website, mobile app, and social media to promote healthy living, offer information on community activities, and guide members to social services. We collect and monitor feedback on our public website and other social media outlets, including Facebook and Instagram. Members can access, complete, and submit an online feedback form on our website.

Formal Surveys to Gather Feedback

We offer members a variety of required and optional surveys to solicit feedback and gauge satisfaction. Table V.F.68-1 describes the mechanisms we have in place to solicit, collect, and act upon the key stakeholder feedback we collect through formal survey processes.

Table V.F.68-1. We Use Stakeholder Feedback from Surveys to Inform Our Quality of Care Delivery.

Survey/Frequency	Description
CAHPS® Survey for Adult and Child Medicaid Plans — Annual	We work with an NCQA-certified vendor to disseminate the survey, including supplemental questions for children with chronic conditions. We use these results to assess member experience with health care services and for members with specific chronic conditions. Results and action plans are reported to MLTC every year.
CAHPS Adult and Child Dental Survey — Annual	For adult members receiving dental services, we will work with an NCQA-certified vendor, other MCOs, and MLTC to administer the dental survey. For children receiving dental services, we will disseminate an MLTC-approved survey to assess timeliness, coordination, quality of care, and provider communication.
Provider Satisfaction Survey — Annual	In collaboration with MLTC and other MCOs, we develop the survey tool and methodology to assess provider satisfaction with credentialing, service authorization, staff courtesy and professionalism, and provider complaints. We report on methods and findings to MLTC within 45 days following the end of each year.
Dental Provider Satisfaction Survey — Annual	We will conduct a dental provider survey to assess satisfaction with enrollment, communication, education, complaints, and claims processing and reimbursement. We will work with MLTC and other Nebraska Health Heritage MCOs to develop the survey tool and methodology.
Additional Surveys that Augment Feedback Gathering	
Post-enrollment Survey — Ongoing	We will begin offering a subset of new members a survey sent via text 90 days following enrollment, to gauge satisfaction with the onboarding process. If a member indicates dissatisfaction, we call to assist and resolve any unmet needs. We will use survey results to improve services for new plan members.
Post-provider Visit Survey — Ongoing	We issue a short survey with modified CAHPS questions via text to a sample of members who have visited a PCP or specialist in the past 60 days. QAPIC accesses results in Tableau, a data visualization tool, to overlay key driver analyses with geographic information. From November 2021 to April 2022, more than 5,370 members responded. From January to May 2022, members reported a high-level satisfaction with PCP and specialists, “Ease of Getting Needed Care” and “Ease of Getting a Check-up or a Routine Care.”
Post-call Survey — Ongoing	We disseminate a brief survey to a sample of members who have called our Member Services Call Center. The automated survey (in English or Spanish) gathers feedback on their experience with Healthy Blue and the call center. When respondents indicate they did not receive the help they needed or were not treated with respect, we call them and ask how we could have met their needs. From January 2022 to date, members have completed 573 surveys and we have followed up with 58 to resolve outstanding issues. ***Since January 2021, members have completed 1,505 surveys and 92% reported they were treated with courtesy and respect.***

Using Feedback to Improve Quality of Care Examples

Example 1. Acting on Feedback to Assure Our Providers Offer Accessible Equipment

During Q1 2022 MAC meeting, a member reported having difficulty finding providers with wheelchair accessible scales and exam beds. Our ***Performance and Quality Improvement Coordinator***, Brittany Kuhns, followed up on this feedback and found that providers listed as offering handicap accessible services do not necessarily have a wheelchair accessible scale or exam bed. To address this, Healthy Blue will create a Community Investment Fund in 2022 to offer grants to providers to purchase durable medical equipment (DME) needed to better accommodate the needs of members with disabilities.

Example 2. Acting on Feedback to Address Access to Care Needs of Mothers and Infants

Following CAHPS for children results related to questions about receiving urgent care, routine care, and specialist appointments, we are implementing a new MLTC-approved non-clinical performance improvement project (PIP) to improve access to pediatric and obstetric care. We will educate members who live in an area with limited pediatric care options about using PCPs for their children. We are also working to contract with providers that practice across state lines and to encourage out-of-network providers to contract with Healthy Blue. This effort will enhance member access to providers who deliver care outside of the state border. Additionally, we will pilot a ***Lodging and Transportation program*** for mothers with high-risk pregnancies, enabling them to access hospitals that offer high-risk pregnancy care that are not close to their homes.

Example 3. Recommendations to Reimburse for Doula Services

During a 2021 public forum held by our Louisiana plan affiliate, stakeholders encouraged the use of doulas to improve birth outcomes. As a result, the plan collaborated with a partner CBO to develop a doula pilot program to provide doula support to members in targeted rural areas and reduce disparities affecting Black members. The CBO will train 10 doulas and offer education and wellness support for up to 75 pregnant mothers within a one-year span.

In Nebraska, Healthy Blue received stakeholder feedback about members’ desire for doulas who reflect the cultural and racial/ethnic preferences of members. We have since partnered with three Nebraskan organizations — ***The Omaha Black Doula Association, Omaha Better Birth Project, and the Malone Center*** — to support building and improving doula services for pregnant members, particularly women of color. We provide funding to these organizations to train and certify Black, Indigenous, and People of Color (BIPOC) doulas, which improves health equity by assuring that BIPOC members receive equitable prenatal and post-partum care.

No. 69

Our Methodology to Identify, Design, Implement and Evaluate PIPs

Healthy Blue uses NCQA standards as the foundation of all our quality activities, and we are fully committed to continuous quality improvement (CQI), which includes performance improvement projects (PIPs). We support state efforts and initiatives to improve health outcomes and quality of life for all our members through collaboration and alignment on joint PIPs with the State and other system partners. We conduct PIPs, including any required by CMS, that focus on both clinical and non-clinical areas. In compliance with the previous state requirements, we historically conducted one clinical and one non-clinical PIP. In the future, we will conduct a minimum of two clinical PIPs and one non-clinical PIP in compliance with the new SOW requirements. We design each PIP to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and include the following elements:

- Measurement of performance using objective quality indicators
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the interventions based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

Healthy Blue has been conducting PIPs throughout our history with MLTC. We conduct PIPs that meet all CMS requirements including 42 CFR § 438.330(d) and that have MLTC approval prior to implementation. Our PIP Taskforce, which manages day-to-day operations of our PIPs, uses Root Cause Analysis and Fishbone methodology to identify systemic barriers for improvement and the Plan Do Study Act process to carefully track and monitor each PIP to verify we adhere to project timeframes, revise interventions to meet quality goals, and help drive new information and interventions to improve quality of care. In compliance with State requirements, we implement clinical PIPs driven by MLTC and their priorities, and for our non-clinical PIPs we review data such as our HEDIS® rates and CAHPS® scores to identify areas where a PIP could help us improve care. We thoroughly discuss our plans for the non-clinical PIP with the State to gather their input on what would best serve Nebraskans and obtain MLTC approval before we implement. We identify PIP goals, strategies, and key performance indicators through a collaborative process with our internal staff, quality committees and external stakeholders. Healthy Blue implements interventions to address the selected strategies, and performance assessments on the selected indicators are based on systematic ongoing collection and analysis of valid and reliable data. Our Quality team analyzes interventions regularly and reports results of the data analysis to our Quality Assessment and Performance Improvement Committee (QAPIC) who is ultimately accountable for all PIPs. We analyze the outcome data to assess for statistical significance at p-values of 0.05 or less and refine interventions based on results, repeating the process until we achieve the desired goal. We complete each PIP in a reasonable timeframe to allow the results to guide our overall quality improvement activities. We report the status and results, including successes and challenges, of each PIP to the State as requested in the annual QAPI Program Evaluation, but not less often than once per year. As appropriate, we address next steps in the QAPI Program Description and Work Plan and implement the PIP recommendations.

We assure PIPs comply with CMS requirements as outlined previously and meet the following standards:

- A clear study topic and question as determined or approved by the State
- Clear, defined, and measurable goals and objectives that we can achieve in each year of the project
- A defined study population
- Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time
- Measures based on current scientific knowledge and clinical experience
- An appropriate sampling methodology resulting in valid, reliable conclusions that are generalizable to the eligible PIP population
- Testing and implementation of interventions and a framework for evaluating the effectiveness of the interventions
- Study methodology is based on Model for Improvement that is rapid-cycle and requires a collaborative approach with cross-functional interdepartmental teams that also include network providers and external community experts and assures increased or sustained improvement over time

In addition to our state mandated clinical and non-clinical PIPs, ***Healthy Blue also conducts quality improvement initiatives that we track and monitor to improve outcomes***. One example of this in our recent ***Population Health Sprint*** where we identified preterm birth rate as a priority for improvement. We reviewed our own claims data and data from the Peristats program from the March of Dimes, which showed that the preterm birth rate for our members who are Black, Indigenous and people of color was 11.35%, which is higher than the national average of 10.23%. We identified a goal of lowering preterm birth rate by 1% and through a collaborative process with our quality committees and external stakeholders established the following strategies to improve preterm birth in our population: early identification of pregnant members who are at risk, increase prenatal and postpartum visit rates, and increase doula utilization both in person and virtually. Performance assessment is ongoing for this process improvement initiative.

Another example of a quality improvement initiative is an oral health project we recently initiated. Data from 2020 showed that the number of practicing dentists in Nebraska who accept Medicaid has declined by 42.3% as compared to 2012, and the number of low-income children aged 1 to 18 in Nebraska who received a preventive dental service through Medicaid or CHIP is lower than the national average. To that end, we are partnering with the Nebraska Association of Local Health Directors to maximize the use of Community Health Workers (CHWs) and dental hygienists as preventive care resources to Medicaid and other patients by expanding the capacity and capabilities of Community Dental Disease Prevention Teams in rural Nebraska Local Health Departments (LHDs). The major focus of this program will be expanding LHDs' capacity through financial support of staff time and through specialized training and skill-building of CHWs assigned to LHDs' oral health programs. The training and skill-building will be available to CHWs and to other LHD staff assigned in other areas. This benefit will be available to staff in LHDs statewide. This is a new program for 2022, but we will monitor and report results as they are available.

Our PIPs Result in Operational Improvements

Since 2018, Healthy Blue has implemented several PIPs that have resulted in operational improvements. Table V.M.69-1 outlines these PIPs and the improvements we have achieved for our members.

In addition to the PIPs that have resulted in operational improvements, we have implemented other PIPs for which outcomes are not yet available. One recent PIP focuses on access to care. Lack of timely access to care can impact all members' well-being and health and the issue affects the health care provider's treatment regime and testing. We selected this PIP to improve access to care for our vulnerable sub-populations: pregnant members and children. The purpose of this project is to achieve significant improvement sustained over time by working with our communities and providers across Nebraska to assure access to care for maternity and pediatric members subpopulation. Our goal is to improve provider accessibility survey results by 10%, decreasing OB-GYN out-of-network (OON) utilization by 10%, and improving HEDIS prenatal and postpartum rates by 10%. We also aim to improve access to care in rural and frontier counties for pediatric members ages 17 and younger by improving provider availability survey results by 10% and Child (ALL) CAHPS questions related to access to care by 5% and by decreasing pediatric OON utilizations by 10%. We will share the results of our findings at the end of our first measurement year in 2022.

Our Plan to Collaborate with MLTC and other MCOs to Conduct Statewide PIPs

Healthy Blue affiliates have extensive experience collaborating with state partners and other MCOs to administer PIPs. ***Using our experience and success with dental PIPs in other markets as a starting point, we will propose to work with MLTC and the Nebraska MCOs to implement a dental PIP to improve care for Nebraskans.*** We are ready to collaborate with the other MCOs and the State to develop a collaborative PIP, and we intend to propose using both the Annual Dental Visit (ADV) PIP from Missouri and the Fluoride PIP implemented in Louisiana as our models to improve dental care in Nebraska. Our Dental QAPIC will oversee our dental PIPs and will also report out through our existing quality committee structure. We will develop an external PIP workgroup to collaborate with state partners on this PIP and assure that all partners support the final PIP plan and that there is agreement on how to evaluate success. In compliance with the SOW, we will address our dental PIP in the annual QAPI Program Description, Work Plan, and Program Evaluation and will report on the status and results of each project to MLTC as outlined in the Quality Strategy.

Our Proposed Dental PIPs Have Proven Successful with Our Affiliates

The dental PIPs in Missouri and Louisiana are two recent examples of PIPs that involved statewide and MCO collaboration and demonstrate our ability to execute dental PIPs. Dental caries disease is preventable yet is the most common chronic disease of childhood in the U.S., and fluoride varnish application for the prevention of dental caries in children is the standard of care in pediatric primary care practice. Guideline recommendations from the American Academy of Pediatrics and the U.S. Preventive Services Task Force recommend that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

The PIP contains the following strategies:

- Creating a Member Fluoride Varnish Care Gap Report, with a version organized by PCP, that identifies all enrollees ages six months through five years who have not received any fluoride varnish application by their PCP or dentist during the baseline year. The gap report would also identify missed opportunities by reporting the number of PCP visits for each child on the list.
- Conducting member outreach to:
  - Educate parents of each child on the Member Fluoride Varnish Care Gap Report about oral hygiene, caries risk and the importance of fluoride (for example, toothpaste, varnish).
  - Link them with a PCP if they do not already have one.
  - Schedule a dental provider appointment and collaborate with MCNA and DentaQuest for dental provider referrals.
- Conducting provider educational outreach to each PCP with patients on the Member Fluoride Varnish Care Gap Report and support by distributing vetted educational materials.

Our affiliate established this PIP in 2021, and we will measure outcomes at the end of 2022 and 2023 to assess the impact of this work. They have identified four separate indicators for fluoride varnish application for children ages 6 months to 5 years with the intention of increasing the percentages of each by three percentage points by the end of 2022.

Making sure all members obtain routine dental care is imperative for overall health for members of all ages. We believe by increasing the number of members obtaining an ADV, the overall health of members will improve.

In Missouri, our affiliate has implemented a PIP focusing on ways to improve the ADV rate for our members. The aims of this PIP are to:

- Increase Healthy Blue's monthly average of eligible members, ages 2 to 20 years of age in 2020, completing an ADV of 2.01% to 4.01% (by two percentage points), in December 2020.
- Increase the Healthy Blue's statewide HEDIS MY 2019 Annual Dental Rate (ADV) rate of 58.87% to 60.87% (by two percentage points), by HEDIS MY 2020.

Healthy Blue Affiliate ADV HEDIS Rate Success

Healthy Blue's Missouri affiliate has had the highest ADV rate among all MCOs for the past three years.

NE_HH22_ HEDISRateSucess_28_COB_01

To meet these goals, we mailed out a Dental Home letter to eligible members in October 2020, which identified the member's Dental Home, the advantages of a Dental Home, and dental benefits available to the member. At the end of 2020, the percentage of ADV compliant members increased from 2% to 4.45% exceeding the goal of 4%. Additionally, Healthy Blue Missouri has had the highest ADV rates in the state among other MCOs for the last three years.

No. 70

Our Approach to the Annual Member Satisfaction Survey

Healthy Blue believes that member experience and feedback data are critical to providing excellent care that meets member needs. We continuously review and analyze member feedback from multiple sources to evaluate whether we are providing the best help for members managing their health care so they can achieve their best health outcomes and improve their quality of life overall. As a component of the State's quadruple aim to optimize health system performance, improved patient experience is an important part of MLTC program participation.

We have codified policies and procedures to govern our approach to measuring member satisfaction and administration of CAHPS®. We conduct and analyze member experience and satisfaction surveys annually and review and analyze member complaints, grievances, and inquiries continuously as an additional measure of member satisfaction. When we identify low or inadequate scores, we analyze the data to identify the root cause and develop a plan to address the issue.

We identify and implement interventions such as changes in workflows or processes to improve member satisfaction. Collecting and analyzing member experience allows us to identify medical and behavioral health aspects of care or service performance that do not meet member expectations. We monitor multiple aspects of member experiences, including member complaints and grievances, member appeals, CAHPS member satisfaction surveys, and quality of care concerns.

Healthy Blue CAHPS Rating

Healthy Blue has a **4-star plan CAHPS rating** with NCQA.

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Healthy Blue contracts with an NCQA-certified vendor to administer CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items. We conduct the CAHPS every year, and these survey results have proved to be an invaluable tool for evaluating and identifying opportunities to improve the access to and quality of care for our members.

In compliance with SOW V.M.12, we use the current version of CAHPS for Medicaid members. For the CAHPS Child surveys with CCC supplemental items, we separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations, separate data and results, and submit reports to the State to fulfill the CHIP Reauthorization Act of 2009 requirement. We include samples of members 18 years of age and older and caregivers and family members of children in all member surveys. Samples are statistically valid random samples that are representative of members, caregivers, and family members enrolled in our plan at the time of the survey. Analyses include targeting improvement efforts and comparison with national and State benchmarks.

In addition to administering CAHPS, we administer a short member satisfaction survey, the Post-provider Visit Survey. Every month we administer the survey to a random sample of members who visited a provider in the previous 2 months. We send the survey to members via SMS using questions modeled after CAHPS. This survey allows us to gather real-time insights from our members more routinely than relying on CAHPS administration alone, and our Quality Management (QM) team reviews the results of this survey to identify and address areas of need in between CAHPS administration. If the response to the survey is negative, we reach out to the member and mitigate the issue they experienced during their visit.

In compliance with the SOW, Healthy Blue will implement a dental member satisfaction survey and conduct the survey annually using an NCQA-approved vendor. We will work with MLTC and any other MCOs to develop the Medicaid child dental member satisfaction survey plan and methodology that all participating MCOs use. We are committed to working with the State and other MCOs to execute the dental member satisfaction survey to best understand the needs of Nebraskans. Our Dental Quality Assessment and Performance Improvement (QAPI) team will oversee dental CAHPS execution. We will report the results of the dental CAHPS to all our quality subcommittees. We will administer the CAHPS dental adult survey to a statistically valid random sample of Healthy Blue members and include statistical analysis for targeting improvement efforts and comparison with national and State benchmarks. The annual survey to assess Medicaid child dental member satisfaction will include the following areas: getting needed care, getting care quickly, coordination of care, quality of care, provider communication to members, and customer service.

The vendor compiles the results, analyzes the data, and provides Healthy Blue with a comparison of performance against national and State benchmark standards. We use the data to evaluate how the plan is performing, identify key drivers of and barriers to improvement, and develop interventions to improve members' care experience with providers and our plan. We submit all reports and action plans derived from these results to the State upon review and approval of the QAPI Committee (QAPIC), and we report survey results and descriptions of the survey process to the State for each required CAHPS survey. We submit our results to NCQA for annual ratings in addition to our HEDIS® rates. Our Member Experience workgroup, an internal cross-functional group, also reviews the results and helps manage member satisfaction assessment efforts, including CAHPS.

Strong CAHPS Results for Our Nebraska Medicaid Members

Adult Medicaid	Rating
Getting Needed Care	★★★★★
Getting Care Quickly	★★★★★
Satisfaction with Plan Physicians	★★★★½
Rating of Personal Doctor	★★★★
Rating of Specialist Seen Most Often	★★★★★
Rating of all Health Care	★★★★
Coordination of Care	★★★★★

NE_HH22_StrongCAHPSResults_COB_02

We review the compiled annual CAHPS member satisfaction survey results to better understand how members feel about the services and care they receive. Our annual QM evaluation documents and tracks this work to identify access and availability issues and other member concerns so we can understand how to improve quality of care for our members. To gain a comprehensive view of our satisfaction results and improvement efforts, we track this data year over year, and we track corresponding interventions in our QM workplan. As outlined in the CAHPS graphic, Healthy Blue's member rating on individual measures from CAHPS meets or exceeds four stars in the following areas: Getting Needed Care, Getting Care Quickly, Satisfaction with Plan Physicians, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care, and Coordination of Care.

Our Survey Results Drive Our Quality Improvements

Healthy Blue routinely reviews data such as HEDIS rates and CAHPS scores to identify areas where we can improve care. We thoroughly develop our quality improvement plans, including goals, strategies, and key performance indicators, through a collaborative process with our quality subcommittees and external stakeholders. We implement interventions to address the selected strategies and systematically collect and analyze valid and reliable data to assess performance on the selected indicators. Our Quality team analyzes interventions regularly and reports results of the data analysis to our QAPIC. Since 2019, we have seen improvements in many CAHPS measures for the Child and Adult CAHPS as outlined in Figure V.M.70-1.

No. 71

Our Experience Submitting HEDIS® Measures

Our Quality program is supported by our commitment to assuring the NCQA accreditation for our health plan, which involves a robust process for the collection and monitoring of HEDIS. The administration of our program is fully compliant with evidence-based standards and performance metrics outlined by NCQA, and we follow Medicaid management best practices, using a proven approach verified by national audit firms. We are a designated 3.5-STAR NCQA Accredited Health Plan, and we understand the importance of using measurement tools to provide consistent assessment of health plan outcomes in support of quality improvement strategies using NCQA Quality Compass percentile, State, and regulatory benchmarks. ***We have been successfully submitting HEDIS measures to NCQA and MLTC for the State Medicaid line of business since 2017 via NCQA's Interactive Data Submission System (IDSS) Tool. Additionally, Healthy Blue submits a formal Final Auditor Report (FAR) administered by our approved NCQA auditor.*** In our years of participating in MLTC, Healthy Blue has always submitted HEDIS data accurately and on time. We also submit rates to the State for ongoing Quality Performance Program (QPP) measures annually.

Robust Data Collection Methodology

Healthy Blue uses sophisticated information systems and data infrastructure to drive high-quality member outcomes. Our robust process encompasses defining the reporting population, hybrid measure project design, year-round data collection and management, and routine monitoring of HEDIS data. Healthy Blue produces HEDIS rates using NCQA-certified software comprised of a data warehouse, which transfers HEDIS relevant data from multiple claims systems and other transaction files. Data sources may consist of any combination of administrative, survey, or medical record data, internally collected, or provided by our subcontractor partners that may help us identify opportunities for improvement, disparities, and effectiveness. Additional data sets may include enrollment information, claims, encounters, authorizations, appeals, complaints, CM documentation, access and availability survey findings, member medical records within provider offices and facilities, immunization registry information, surveys by external bodies such as accreditation entities or CMS, QI studies, state data files, CAHPS®, and HEDIS results.

Our QAPI program incorporates our proprietary internal Interactive Analytic Insights platform and HEDIS Data Mart. These resources systematically and objectively measure access to care and demand for services. Our national Medicaid division also offers an enterprise data warehouse to support operational processes, analytics, and reporting. This real-time repository creates flexibility for rapid development and deployment of any new data exchange through secure data transfer. It collects and aggregates data into a comprehensive source of health information about our members — including types of encounter data, lab results, and immunizations including electronic health record (EHR) and health information exchange (HIE) data. Additionally, the data warehouse supports access to member data through our care management system, Health Intech. We will also continuously leverage our experience in other markets where our affiliates use best practices to expand data assets and reporting capabilities to better address health outcomes.

Sampling Methodology

We select samples based on the indicator or measure to be evaluated and identified in the written documentation of monitoring activities. We use statistically valid sampling for data collection when appropriate, including HEDIS specifications, as applicable. Additionally, we determine sample size to select a target variance derived from the sample. For example, when we collect data for our PIPs, we determine if the random statistically significant sample has a confidence interval of 95% or -5 to assure our sample is representative of the population.

Data Collection and Analyses

We continuously collect quality data, as well as at systematically specified intervals such as daily, weekly, monthly, quarterly, and annually. We include data collection and reporting frequency in the QM Work Plan for each measure or activity. We report data results in a comprehensive Data Analysis and Evaluation Report. Additionally, we conduct quantitative and qualitative analyses to evaluate the effectiveness of activities in achieving clinical and service performance goals. Among other domains, these analyses consider potential barriers for achieving desired outcomes and interventions or recommended strategies. We may initiate revisions to the QM Work Plan in collaboration with MLTC in response to findings or reprioritization of projects and new events. We communicate analyses and QM program reports to the relevant quality committees. At least semi-annually, Healthy Blue disseminates information about the QI program and progress toward goals to members and providers. We will also share data and reporting to the MLTC on a routine basis.

Data Validation

Healthy Blue uses an NCQA-approved auditor to vet and approve all our final HEDIS rates. The auditor separately validates each source of supplemental data, including reviewing policies, procedures, data file formats, and quality control processes. Robust policies and procedures govern HEDIS measurement collection and submission. These policies define and establish the HEDIS administrative and hybrid data collection and rate generation process, how to monitor and support quality improvement initiatives through HEDIS and state performance reporting, how to assure comprehensive corporate and health plan collaboration on HEDIS process projects, and establishes a monitoring processes to support the accuracy and integrity of information collected and distributed to regulatory state and federal agencies and organizations conducting accreditation such as NCQA.

Monitoring and Oversight

Our local QM Coordinator is accountable for all HEDIS data management and reporting with support from Healthy Blue's dedicated QM Data Analyst. Additionally, we collaborate with our national Quality Data Management team to perform all file consolidations, extractions, and derivations.

No. 72

Healthy Blue's Clinical Advisory Committee Vision

Quality is part of our collaborative culture as a health plan, and we consider all Healthy Blue staff to be quality champions. Our approach is rigorous, systematic, and designed to continuously improve results for all members and providers. ***Since 2017 Healthy Blue has maintained a Clinical Advisory Committee (CAC), in compliance with SOW V.M.6, to provide input on policies and procedures related to care management, case management, utilization management (UM), including clinical practice guidelines and UM criteria to assure that the standards are up to date with evidence-based practices.***

Healthy Blue Has Robust Experience with Committees

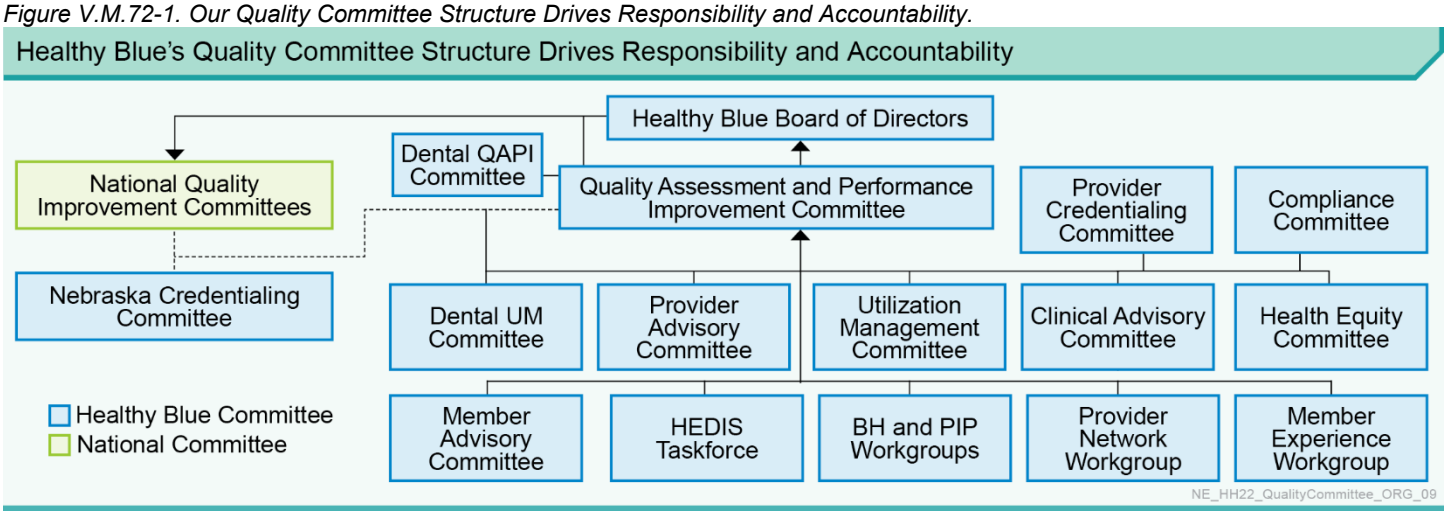
Healthy Blue has an established history of implementing a robust and well-rounded committee structure in compliance with the NCQA and MLTC requirements. We understand the importance and value of this structure to execute and oversee work plans to meet goals that align with MLTC's goals and objectives. We currently operate more than 10 committees, workgroups, and taskforces focused on quality with representation from health plan leadership, clinical experts, members, and their advocates representing diverse populations.

CAC Committee Structure

Our Chief Medical Officer, Dr. Debra Esser, chairs the CAC, which is comprised of representatives that cover a variety of medical specialties such as primary care, behavioral health, specialists in addictionology, endocrinology, physical and occupational therapy, obstetrics, and reproductive health. In compliance with SOW V.M.7, the CAC includes 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. By the new Contract Start Date, we will assure we have representation from at least one dental provider on the CAC in compliance with the SOW. Our CAC reports to the Quality Assessment and Performance Improvement Committee (QAPIC), which maintains ultimate oversight and accountability over Healthy Blue's QAPI program.

Our CAC works collaboratively with our other quality committees, as outlined in Figure V.M.72-1, and all committees report up to our QAPIC, which assures coordination among the committees and no duplication of quality efforts across the organization.

Figure V.M.72-1. Our Quality Committee Structure Drives Responsibility and Accountability.



The CAC meets quarterly, supported by meeting agendas that include standing topics such as UM, population health, QI/QM, cultural competency topics, member and provider experience, coordination of care, provider engagement, medical policies and guidelines, policies and procedures, and state required reporting. We document all CAC meetings formally through minutes, which our voting membership approves. We value our members and invite them to attend CAC meetings to provide insight on their behavioral health and physical health experiences. Their unique perspectives add depth and real-life application for the topics we discuss. We are growing our member attendance and plan to reinitiate in-person meetings before the end of 2023. We will submit to MLTC for approval our plan for development of the CAC a minimum of 90 calendar days prior to the Contract Start Date and annually thereafter. Additionally, we will submit copies of the committee's minutes to MLTC as requested.

Our CAC Purpose

The purpose of our CAC is to review and provide input on policies, procedures, and practices associated with care management and UM to make certain that our standards and practices align with current best practices. This includes reviewing standards and practices related to treatment, levels of care, quality of care and utilization. Being comprised of experienced providers, the CAC is well-positioned to communicate directly and solicit feedback and recommendations from our network providers, which is a critical aspect to much of their work. For instance, they obtain and interpret provider feedback and recommendations for developing and monitoring clinical policies and operational enhancements and provide advice to the corporate committee who oversees development of clinical practice guidelines. They also provide a venue for direct provider feedback and establish the process for responding to provider concerns. The CAC routinely conducts peer review processes for monitoring care quality, appropriateness, and treatment utilization, and they also help develop provider training and solicit provider feedback on education and training opportunities. The CAC works closely with our QAPIC to provide oversight and input on the Population Health Management work and Health Equity Strategy.

Roles and Responsibilities

Our CAC executes numerous quality responsibilities, some collaboratively with the other quality committees, including:

- Using ongoing peer review system to assess levels of care and quality of care provided
- Providing input into all practices associated with care management and UM functions, including clinical and practice guidelines, and UM criteria to make sure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the state
- Reviewing and approving UM Work Plan, UM and care management Program Description and UM Evaluation
- Monitoring practice patterns to identify appropriateness of care and for improvement and risk prevention activities
- Reviewing and providing input based upon the characteristics of the local delivery system
- Approving evidence-based clinical protocols and guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Reviewing clinical study design and results
- Developing and approving action plans and recommendations regarding clinical quality improvement studies
- Considering and recommending actions about physician Quality of Care issues
- Reviewing and providing input to clinically oriented QM policies and procedures, UM policies and procedures, and Disease and case management policies and procedures
- Reviewing and approving significant changes in guidelines prior to adoption
- Reviewing and providing feedback regarding new technologies
- Reviewing and approving initial practice guidelines
- Overseeing compliance of delegated services
- Soliciting feedback from the corporate CAC
- Obtaining feedback and proposals on topics of interest for all provider types for monthly newsletter articles and input on the provider handbook update

Our CAC Work Improves Clinical Practices and Processes

Our CAC has worked to improve our practices and processes in numerous ways and has been instrumental to improving our UM program processes. We outline a few recent examples related to our UM program in Figure V.M.72-2.

Figure V.M.72-2. Our Clinical Advisory Committee's Work Has Improved Our Processes.

Clinical Advisory Committee Work in Action

Healthy Blue's 2020 Utilization Management Program Evaluation was presented to the committee for recommended actions. The CAC made the following recommendations:

1. Restructure medical and behavioral health teams to integrate into the Clinical Solutions team and Diversified Business Group enterprise structures and to promote alignment of internal policies and processes.	2. Use reporting to identify and drive targeted inpatient metrics such as readmissions, short stays, and Average Length of Stay (ALOS).	3. Standardization and dissemination of best practices to empower staff to perform at their highest potential and reduce variability in operations.

Additionally, for the 2021 Annual Provider Survey, the CAC implemented an additional provider satisfaction survey to better understand provider experiences and areas of deficiency.

NE_HH22_ClinicalAdvisoryCommitt_COB_02

We have completed our restructure of the physical and behavioral health teams, and we are in process of improving our reporting of inpatient metrics and standardizing staff best practices. Due to these recommendations, UM has enhanced their training and use of digital tools, which resulted in the physical health UM team scoring 100% for their Performance Improvement and Enhancement audit for three consecutive months in the first quarter of 2022.

Additional policy and guideline changes that resulted from CAC input include:

- Changing the OB Ultrasound policy to include first two scans without prior authorization
- Changing policy to cover in-home sleep studies
- Adding new lab tests to our covered services
- Changing surgical policies to cover bilateral surgeries such as hernias
- Adopting enhanced review of post operative wound vacuum pumps and supplies to meet new standards of care

No. 73

Our Health Equity Committee Vision

Healthy Blue shares MLTC's focus on reducing health disparities, addressing social risk factors, and achieving health equity. Our health equity work is rooted in the foundation of improving health outcomes and addressing disparities. ***Healthy Blue maintains a Health Equity organizational and committee structure that supports a culture of continuous quality improvement; reinforces clear accountability and inclusive participation by a wide range of constituents, including community stakeholders, members, and network providers such as the Malone Center in Lincoln and the Omaha Black Doula Association; works to achieve health equity and reduce health disparities; and blends local and national resources that align with MLTC goals.***

Healthy Blue's Robust Experience with Committees

Healthy Blue has an established history implementing a robust and well-rounded committee structure in compliance with NCQA and MLTC requirements. We understand the importance and value of this structure to execute and oversee work plans to meet goals that align with MLTC's goals. ***We currently operate more than 10 committees, workgroups, and taskforces, including a Health Equity workgroup*** that we will formalize into our current committee structure. Our committees include representation from health plan leadership, clinical experts, members, and their advocates, representing diverse populations. Our committee structure emphasizes inclusion of stakeholders, such as providers, members, and community organizations, to develop sustainable interventions to meet MLTC's goal of improving quality outcomes and consistency of care across the delivery system. Healthy Blue's Quality Management (QM) program fosters local decision-making enhanced by the knowledge and perspective of our national team and affiliates who share successes and lessons learned.

Committee Structure

Our cross-functional team structure has and will continue to integrate quality improvement (QI) and health equity activities, contributing to our successful implementation of disparities-focused activities and health equity PIPs. Since 2017 our Population Health Workgroup has served as our informal health equity committee led by Dr. Rob Rhodes, our Chief Executive Officer, and Julie Godbout, our Grievance System Manager. With ***Tiffany White-Welchen as our new Health Equity Director***, we will transition to a formal Health Equity Committee (HE Committee) structure with Ms. White-Welchen as chair.

Healthy Blue's Health Equity Framework

Our Purpose: Improve the health of humanity
Our Mission: Improve lives and communities. Simplify health care. Expect more.
Our Vision: Be the most innovative, valuable, and inclusive partner.
Our Values: Leadership, community, integrity, agility, diversity
Our Community Health Strategy: Racial justice, social justice, health equity.
Our Health Equity Strategy: Optimize health outcomes and advancing health equity for members. Address whole-health needs to improve health, affordability, quality, and access for individuals and communities.

NE_HH22_HealthEquityFramework_COB_03

The HE Committee will meet quarterly, supported by meeting agendas that include standing topics such as population health, QI/QM, Culturally and Linguistically Appropriate Services (CLAS) cultural competency topics, member experience, social determinants of health (SDOH), access to care barriers, and provider engagement. We formally document all meetings through minutes, which our voting membership approves, and we submit copies of the committee's minutes to MLTC as requested. The new formal HE Committee will include representatives from Healthy Blue leadership; Care Managers, members representing the geographic, cultural, and racial diversity of our plan's membership; community leaders; our Provider Network Manager; and the Quality Assessment and Performance Improvement (QAPI) Program Manager. The committee will include representatives from diverse backgrounds and staff from other areas of our organization.

Healthy Blue's Health Equity Committee Representatives

The Health Equity Committee will include representatives from diverse backgrounds and staff from other areas of our organization, including:

- Population Health/Clinical
- Operations/Data Analytics
- Medical Directors
- Behavioral Health
- Care Management
- Utilization Management
- Housing and Employment Specialists
- Provider Experience

NE_HH22_HealthEquityComm_COB_04

Our QAPI Committee (QAPIC) is responsible for organizational governance and will be the governing body of the HE Committee. The QAPIC will annually approve our QI and Health Equity Program Description, Work Plan, and Program Evaluation. Our QAPIC leverages the expertise of our national Medicaid Quality Improvement Committee to review our health equity activities, review quarterly reports, and make recommendations. Our QM Director is a member of our national Medicaid Quality Improvement Committee. Our HE Committee will also collaborate closely with our Member Advisory Committee (MAC) and Clinical Advisory Committee (CAC), which serve to gather member and provider input on planning and delivery of services; QAPI/QI activities; program monitoring and evaluation; and member, family, and provider education. Our QAPIC oversees both the CAC and the HE Committee, which will facilitate a close working relationship that benefits both committees.

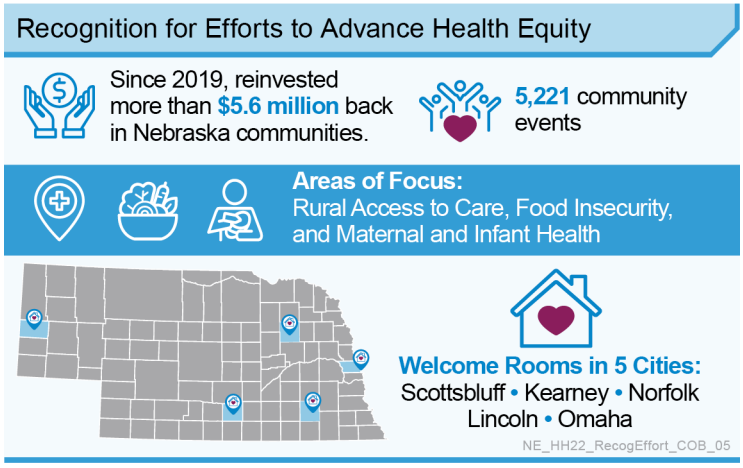
Roles and Responsibilities

Our HE Committee will meet quarterly to discuss findings attained from ongoing activities of smaller teams that address the key priorities outlined in the graphic. The diverse members who make up the committee are responsible for enacting the necessary cultural and ethical changes to deliver the best services possible to all our members and will have the following duties and responsibilities:

- Providing guidance and oversight on Population Needs Assessment
- Reviewing dashboards of data; assessing performance outcomes on the identified goals and initiatives
- Providing governance to promote health equity in cross-functional programs and advocating for internal health equity training
- Supporting strategy and solutions for identifying and addressing health disparities based on data and current community needs
- Identifying disparities in health care access and availability, service provision, member satisfaction, and outcomes
- Obtaining data on race, ethnicity, geography, language, and SDOH
- Assuring culturally competent service delivery and promoting implicit bias awareness, including obtaining ongoing input from caregivers and families with disparate outcomes when designing services and interventions
- Collaborating with members, MCOs, providers, and staff to test, refine, and share successful strategies for reducing disparities
- Engaging with individuals and organizations to understand community needs and address SDOH-related needs
- Assuring the active oversight of referral and follow-up process on identified SDOH needs

Our Health Equity Work Improves Outcomes and Reduces Disparities

Healthy Blue understands the critical role that race, geography, culture, and ethnicity play in the health of individuals, and that members are most likely to access care and follow treatment plans when health care systems and services are culturally competent and linguistically accessible. To this end, we have developed policies, procedures, and practices that adhere to the National Standards for CLAS in Health and Health Care. We are in the process of receiving the ***NCQA Distinction in Multicultural Health Care***, and we will pursue NCQA's new Health Equity Accreditation upon its availability. Annually, our Healthy Blue Board of Directors and multiple quality committees review our CLAS and Health Disparities Evaluation, and our Health Equity Plan will include these elements.



We have worked on numerous projects to improve health equity across Nebraska, with a focus on the health needs of our members living in rural areas. In conjunction with members, providers, and other stakeholders, we will develop a comprehensive Health Equity Plan as part of our QAPI program, aligned with Nebraska Medicaid Managed Care Quality, to address the digital divide, infrastructure challenges, and obstacles faced by subpopulations such as tribal communities. Healthy Blue works with organizations, members, providers, and other key partners on data-driven improvement projects that address disparities in health care, social resources, and health equity. Through our work to identify disparities, we recently completed ***a Population and Rural Health Sprint*** to inform and identify areas of focus to close health disparities. Programs we have or will implement include:

- **Transportation for Rural Members.** [redacted]

No. 74

Practice of Profiling Quality of Care Delivered by PCPs, Specialists, and Hospitals

Profiling the quality of care delivered by our providers is a key component of our Quality Assessment and Performance Improvement (QAPI) program and is essential to our collaborative approach to provider performance improvement. Our multifaceted profiling approach recognizes the diverse needs that providers have for measurable, actionable, and relevant profiling information. Our profiling approach includes a structure for developing quality reports, a methodology for selecting profiling measures, and established frequencies for each profiling activity. In addition, we align provider profiles with our value-based purchasing (VBP) programs, and drive performance improvement by linking provider payments to measures of quality and efficiency. Profiling data is tracked and monitored through our Quality Assessment and Performance Improvement Committee (QAPIC). As part of our commitment to ensuring that our membership receives high quality care, Healthy Blue sets annual performance goals focused on assigning members to high quality providers. As described next, Healthy Blue providers receive an enhanced array of performance reporting, including Quality Profiles, scorecards, action plans, and interactive management tools to drive performance improvement. We use quality of care incidents, grievances, appeals, and member satisfaction (for example, CAHPS® data to profile providers and track quality of care). Healthy Blue uses the following profiling approaches indicated in Table V.M.74-1 as the foundation to ensuring quality of care delivered by PCPs. Sample reporting for each profiling approach is indicated in Attachment V.M.74-1: Sample Quality Reports.

Multi-dimensional Provider Profiling

Our multi-dimensional approach to provider profiling and performance information-sharing aligns with our network performance optimization strategy and APMs. ***Together, these combine actionable information with performance incentives maximizing improvement in outcomes.***

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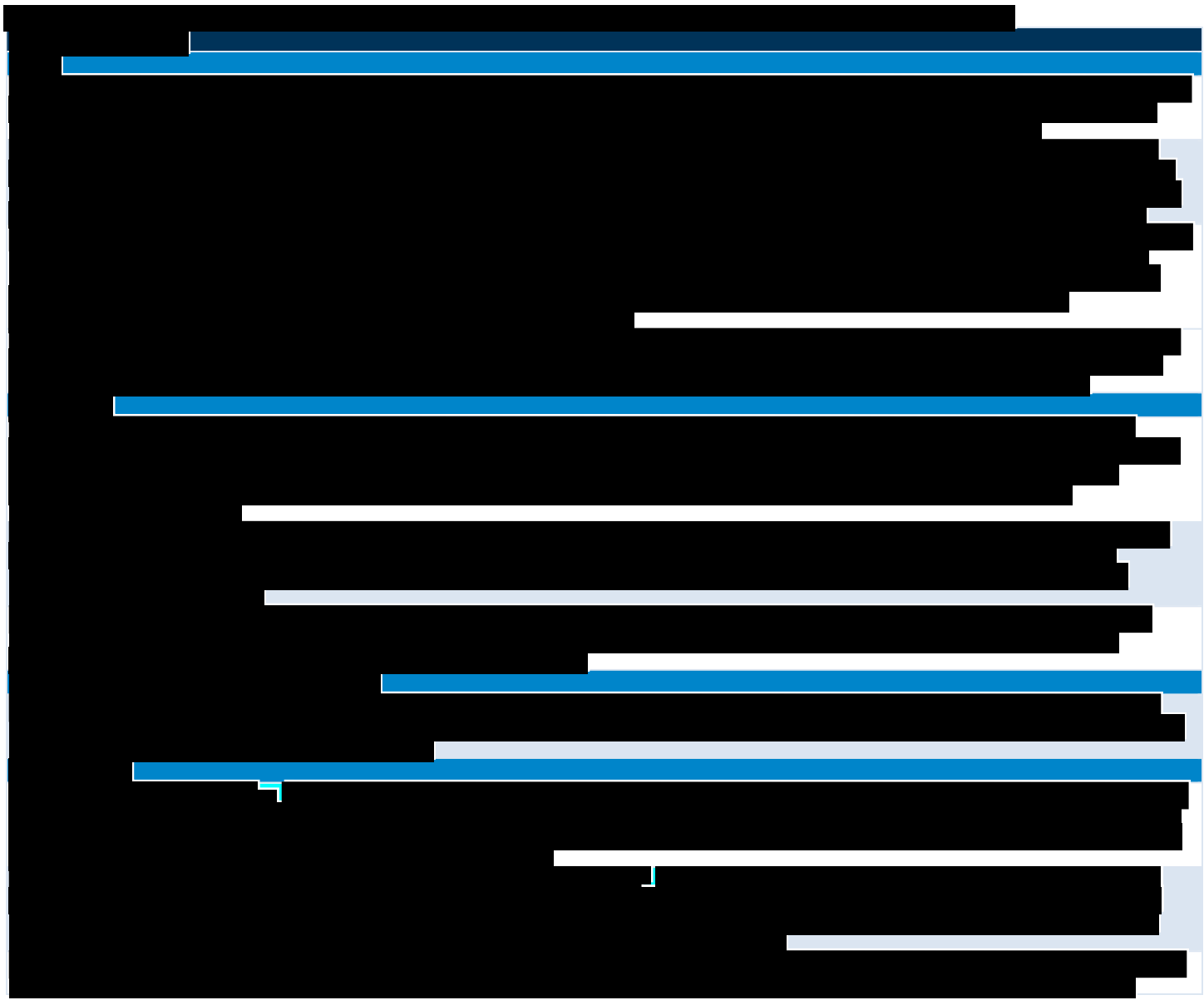


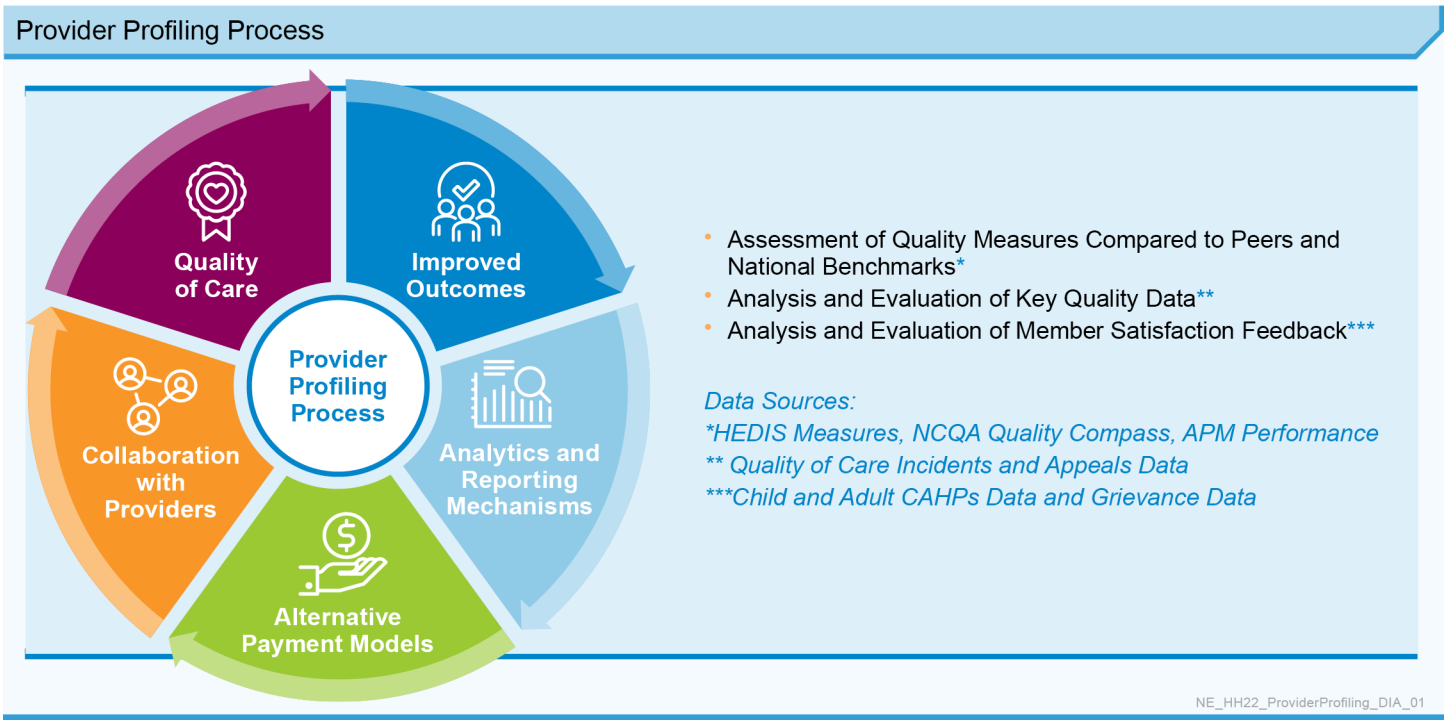
[redacted]

Determining Which and How Many Providers Are Profiled

Our methodology to determine which providers are profiled is driven by our goal to improve performance and see that the majority of our members are cared for by high performing, engaged providers. Each methodology reflects specific technical and operational requirements to accurately measure, ensure statistical validity and compare performance based on the type of profile. We base the number of providers profiled on the minimum number of members needed for valid measurement for each profile report. For example, our PCP Quality Profile Report has a minimum threshold of 100 members to maintain validity. Though our provider profiling processes, shown in Figure V.M.74-1, we actively educate, counsel, and hold providers accountable for driving positive change.

Our local and well-qualified QM team is dedicated to our provider profiling process. Healthy Blue has a dedicated Quality Data Analyst who is responsible for collecting and analyzing data for quality management on member and provider outcomes including disparities data, care gaps, SDOH data, claims analysis, EPSDT services management, Well-baby and Well-Child assessments, immunization services and grievances and appeals. The QM team works closely with other departments such as Provider Experience and CDT Consultants to advise on provider and measure profiling activities.

Figure V.M.74-1. Healthy Blue's Provider Profiling Process Methodologies.



Rationale for Selecting Performance Measures

We strive to incorporate measures into our profiling and VBP strategies that are reliable, measurable, and actionable through intervention with our providers. When possible, we leverage standardized quality and efficiency measures because they are well-validated, represent industry standards, and are familiar to providers. Measures are also closely linked to our QAPI program, which relies on data to manage work, focus activities, and enhance provider partnerships. Aligning measures across our programs helps us identify and prioritize opportunities for improvement, as well as focus on activities that have the greatest potential to positively impact our overall membership. We engage providers through multiple means, including our Provider Advisory Committee, for input on the development and design of profiles and VBP measures and methodologies to maximize effectiveness.

Measures are chosen based on a variety of data sources, as referenced in Table V.M. 74-2. For example, our new PCP Quality Profile includes HEDIS measures for adult access to preventive health services, comprehensive diabetes care, breast and cervical cancer screenings, antidepressant medication management, and diabetes screening for people with schizophrenia and bipolar disease who are using antipsychotic medications. We strive to select measures that can be calculated from claims or encounter data, and tie to quality goals, to minimize administrative burden and enable a more rapid feedback cycle.

Table V.M.74-2. Data Sources That Inform Measure Selection for Provider Profiling.

Data Source	Description
NCQA HEDIS Measures and Quality Compass Benchmarks	HEDIS®-based measures inform our models because they are well-validated, represent industry standards, and are familiar to providers. We also prioritize measures that may be calculated using claims or encounter data or are available through a health information exchange to minimize the administrative burden on providers and enable a more rapid feedback cycle.
MLTC Priorities	We include measures that reflect key health indicators related to our member populations in alignment with MLTC's goals and quality measures, relevant performance improvement projects, and the Quadruple Aim.
Grievances and Appeals	Aggregated grievance and appeal data allows us to do trend analyses on number received, the type and name of provider, descriptions, timeliness of resolution and outcome. This data is reported out quarterly in our Quality Committee Structure and annually for a formal evaluation and informs ongoing evaluation and selection of measures for provider profiling.
Quality of Care Data	The Quality Management Department utilizes reports generated on potential and identified quality of care issues/events to monitor, track, and trend practitioner performance. These trends are reported up to the Clinical Advisory Committee and the QAPIC has oversight of this process. Data from these reports informs the ongoing evaluation and selection of measures for provider profiling.
Peer-to-peer Performance Data	Provider performance on key quality measures is benchmarked against peers to identify high and poor performing metrics to identify opportunities in prioritizing key measures to including in profiling activities to improve overall outcomes.
Provider and Member Feedback	Provider and member feedback inform the selection of measures through advisory committee review (Provider Advisory Committee, Member Advisory Committee) and regular review of CAHP results in evaluating provider profiling measures.
VBP Program Outcomes	We align our VBP program measures and targets to advance the Nebraska DHHS Quality Strategy for Heritage Health and the Dental Benefit Program, and MLTC goals of improved quality, access, and outcomes. Our measures are reviewed, and adjusted if needed, annually to assure continual alignment with MLTC priorities and provider profiling is adjusted in response to VBP program outcomes.

Healthy Blue continuously evaluates our profiling approach and methodology to verify our members are receiving quality care leading to improved outcomes. With performance targets in mind, we choose measures to improve outcomes, study the performance of those metrics, then repeat the process using the rapid-cycle Plan-Do-Study-Act method. This ability to quickly refine our profiling approach is key to sustained and significant improvements. We evaluate and determine performance though data collection and provider feedback, with a focus on our targets. As we identify both successes and opportunities for improvement, we share performance data with our Advisory Committees, community-based organizations, providers, and other stakeholders.

No. 75

Our Member Advisory Committee Provides Critical Insight to Our Plan, Quality of Care, and Operations

Healthy Blue CAHPS Rating

Healthy Blue has a **4-star plan CAHPS rating** with NCQA.

NE_HH22_CAHPS_NCQA_COB_01

Healthy Blue systematically seeks input from a variety of stakeholders and partners, including populations experiencing disparities, on their most pressing health concerns, and we gather feedback and recommendations on activities and initiatives meant to address these challenges. Our ***Member Advisory Committee*** (MAC), in place since 2017, provides an interactive forum in a structured format for us to listen to member and stakeholder feedback and recommendations about our Healthy Blue planning and delivery of services, quality improvement activities, program monitoring and evaluation, and member, family, and provider education. The MAC provides a valuable setting for collecting input regarding such topics as health care needs, resource gaps, potential value-added services, barriers to care, telehealth offerings, and more. During our MAC meetings, we encourage members, stakeholders, and partners to ask questions. Common questions and topics include PCP selection, care management assistance, transportation, incentives, enhanced services, Health Risk Screening, and how to access community resources.

The MAC also provides input regarding education and outreach programs, helps inform our health literacy campaigns, and assures grievance and appeal resolution processes are culturally and linguistically sensitive, and capable of identifying, preventing, and resolving member grievances and appeals. We use insights gleaned during MAC meetings to identify areas of opportunity related to quality of care, access, and our operational performance. This includes making improvements such as identifying providers who can meet members' cultural, racial, and linguistic preferences; increasing access to accessible equipment; and creating new member tools such as short and easy how to videos about how to download and use our member app.

The MAC is overseen by our Healthy Blue ***Quality Assessment and Performance Improvement Committee*** (QAPIC) team and meets quarterly. We collaborate with members to create formal agendas and meeting topics. Since the COVID-19 pandemic, we have held virtual MAC meetings via teleconferencing to assure members and stakeholders could continue to provide feedback on our programs and service delivery. We will recommence in-person MAC meetings in Q3 2022 but will continue to offer a virtual option so that members and stakeholders from all across the state can participate. We also leverage our five ***Welcome Rooms*** across the state, located in Kearney, Scottsbluff, Lincoln, Omaha, and Norfolk, to telecast the virtual meetings for those members who have limited access to internet and broadband or Wi-Fi services. For members attending the MAC meetings in our Welcome Rooms, we offer lunch, a gas card to assist with transportation, [redacted]

Healthy Blue Community Relations staff who attend MAC meetings (in-person or virtually) are bilingual in English and Spanish and can offer real-time interpretation for members whose preferred spoken language is Spanish. Additionally, for members attending the MAC meetings in our Welcome Centers, we offer our ***translation kiosks*** for real-time interpretation in more than 230 languages including American Sign Language (ASL).

Identifying Participants and Assuring Representation of MAC Membership

The MAC is comprised of members, their family members or caregivers, providers, and other stakeholders and advocates. We have no restrictions on MAC membership and open the MAC up to all members who wish to participate. We inform members about the opportunity to participate through our member handbook, welcome calls, and invitations to participate on our website. To assure the MAC composition reflects the attributes of our membership, we are going to conduct more focused outreach and education about the MAC to independent living centers and Tribal communities, with the goal of diversifying our MAC membership so that it includes representation of racial/ethnic groups and linguistic groups representing at 5% of eligible individuals. MAC members are provided an orientation and offered ongoing training opportunities to assure their understanding of managed care programs to fulfill their responsibilities. To remove barriers for interested members, MAC members are provided reimbursement for travel costs for those who elect to attend in person.

Currently, our MAC membership is made up of more than 45 external members, including stakeholders, such as Nebraska DHHS, MLTC, providers such as CHI Health and Bryan Health, plan members, and representatives from trusted community-based organizations (CBOs) representative of more than 15 different zip codes across Nebraska, representing both rural and urban communities. In addition, MAC membership includes representatives from the Ponca Tribe of Nebraska, MLTC, Medicaid and long-term care experts, and health care providers. We invite key CBO representatives and other stakeholders to participate in the MAC.

MAC members include representatives from a variety of partner organizations offering key supports and services to our Nebraska members. We leverage relationships with our MAC members to better understand the communities we serve. MAC members include community partners, including CBOs and faith-based organizations (FBOs), health departments, Federally Qualified Health Centers (FQHCs), community mental health centers, homeless shelters, food banks, and governmental agencies. For example, current MAC members include representatives from the following organizations:

- **Behaven Kids.** A youth and adolescent behavioral health (BH) provider serving plan members in the Lincoln and Omaha area
- **Lutheran Family Services.** Provides child, community, and BH services to members across Nebraska
- **Nebraska Aids Project.** A community provider focused on overcoming HIV/AIDS and its stigma across Nebraska
- **Building Blocks Foster Care.** Offers personalized support to foster parents, respite services, and quality foster care placements for children and families in 50 counties across Nebraska
- **Omaha Healthy Kids Alliance.** An environmental health CBO focused on improving children's health through healthy homes
- **Cedars Bridges and Street Outreach.** Offers services to help children and youth achieve safety, stability, and enduring family relationships in Lincoln
- **Community Action Partnership of Western Nebraska.** A Western Nebraska FQHC with clinical health services, community health services, and supportive health services
- **US Department of Veteran Affairs.** Serves veterans and their families by providing veterans services across Nebraska
- **DOVES.** Provides services for adult and child victims of domestic and dating violence, sexual assault, and stalking in Nebraska

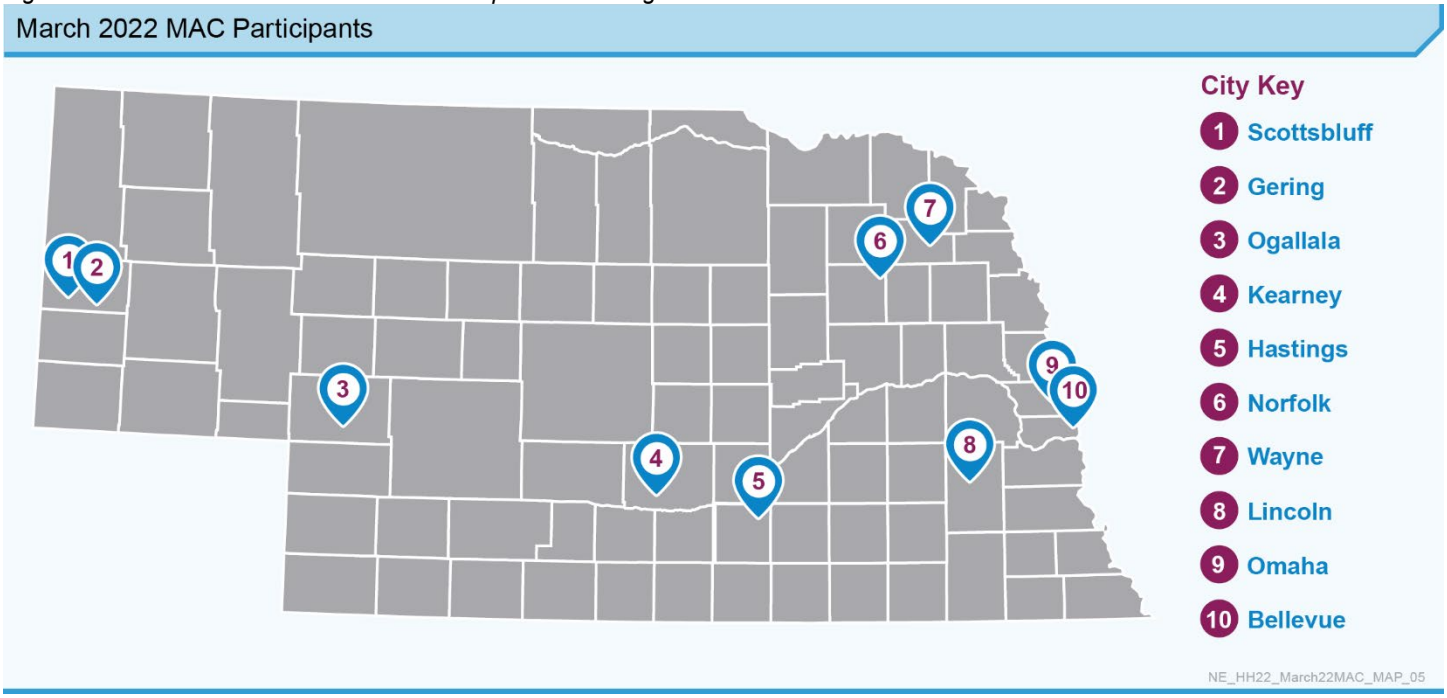
- **Family CARE.** A CBO focused on providing advocacy, resources, serving members in central Nebraska through peer support specialists, and transitional youth advocates
- **Buffalo County Community Partners.** Uses a collective impact model to improve the health and well-being of Central Nebraska community members
- **Liberty Centre Services.** A mental health and substance use provider serving plan members 19 years and older in the Norfolk community for over 30 years.
- **Educational Services Unit 13.** Provides educational services to support and empower educational excellence for all learners across the Nebraska Panhandle counties

Current MAC Membership and Responsibilities

LOCAL LEADERSHIP

Our Healthy Blue MAC membership reflects the geographic, cultural, and racial diversity of Medicaid members. To diversify our MAC composition to better reflect the attributes of our membership racial and ethnic groups and linguistic diversity, we will conduct more focused outreach and education about the MAC to independent living centers and Tribal communities, Figure V.M.75-1 depicts the geographic distribution of our current MAC members. Our ***MAC Plan***, approved by MLTC, describes our meeting schedule and goals, and we consistently submit MAC agendas minutes and semi-annual reports to MLTC as required. We collaborate with the MAC each year to approve a ***MAC Charter***, which includes details about the purpose of the MAC and MAC member roles and responsibilities as detailed next.

Figure V.M.75-1. Our 2022 MAC Members Represent All Regions of Nebraska.



The MAC's ***purpose*** is to engage and solicit member input and feedback on a variety of plan topics, including:

- Providing input and feedback regarding health education and outreach development
- Providing input and feedback on offered benefits and services, policies and planning, and delivery of services
- Assisting with assuring all materials and programs meet cultural competency requirements and address Healthy Blue members' health education and literacy needs
- Assisting in the review, development, implementation, and evaluation of member health education tools for our outreach program to make sure our materials and tools are easy to understand and accessible
- Reviewing and making recommendations on health education strategies for members, their family members, and providers
- Participating in quality improvement activities, program monitoring and the evaluation of the delivery of services for members, their family members, and providers

MAC members are ***responsible*** for assisting the plan in a variety of ways, including:

- Decision making in the area of member grievances, marketing, member services, outreach, case management, and cultural competency
- Identifying health education needs of members based upon review of demographic and epidemiologic data
- Reviewing and addressing issues raised by members, their family members, and care givers
- Providing input into annual review policies and procedures, program results and outcomes, quality improvement activities, and future goals and interventions
- Identifying cultural values and beliefs that must be considered in the development of culturally competent health education programs
- Reviewing and providing input on our Culturally and Linguistically Appropriate Services (CLAS) program description, evaluation, and workplan to assist us with our pursuit of the NCQA Distinction in Multicultural Health Care acknowledging our work in providing CLAS that work to reduce health care disparities
- Reviewing, developing, implementing, and evaluating member health education tools for the outreach program
- Reviewing language utilization for members and providers

Examples of Member Feedback Resulting in Quality of Care and Operational Improvements

We listen to member feedback and act upon it to improve our quality of care and plan operations. Feedback and opportunities for improvement provided during MAC meetings are provided to the QAPIC for review and action. Some examples of how Healthy Blue and our affiliates in other states have collaborated with members for program improvements include:

Example 1: Acting on Feedback to Assure Our Providers Offer Accessible Equipment

During a Q1 2022 MAC meeting, a Healthy Blue MAC member expressed the desire to locate providers equipped with wheelchair accessible scales and exam beds. To address and respond to the member issue, our cross-sectional team, including QAPIC team members, conducted research into this request and determined that although a provider may be listed as handicap accessible, this did not indicate the provider offered an accessible scale or exam bed. Although this improvement is in the beginning stages, to address member concerns, Healthy Blue is planning to create a Community Investment Fund by end of 2022 to offer grants to providers to purchase durable medical equipment (DME) needed to better accommodate the needs of members with disabilities.

Example 2: Acting on Feedback to Assure Availability of Provider Linguistic, Race, and Cultural Competency

Our Nebraskan CBO partner, the ***Omaha Black Doula Association***, relayed to us that members wanted more information about our network providers' linguistic, race and ethnicity, and cultural competency as it would help them select a PCP based on their individual preferences. In 2022, we began asking providers who volunteer to self-report their race and ethnicity. For those that do opt-in to this information sharing opportunity, we include the information in our provider directory, in addition to the languages that individual providers speak.

Example 3. Acting on Feedback to Create How-to Videos for Members

In a Q4 2021 MAC meeting, a Healthy Blue member offered feedback regarding their interest in having short instructional videos about general plan functions such as how to download the member app, how to select a PCP, and how to complete their Health Risk Screening (HRS). To meet member needs, our Quality and Member Engagement teams are creating a series of short, easy-to-access how-to instructional videos that are posted on our website currently and are in the process of developing additional videos to post by Q4 2023. The videos include instructions and video visual aids on the following subjects:

- How to download member app
- Understanding covered benefits
- Understanding HRS and how to complete it
- Understanding PCP importance and how to change PCPs
- Understanding the emergency department (ED) services versus urgent care clinics for unplanned health needs

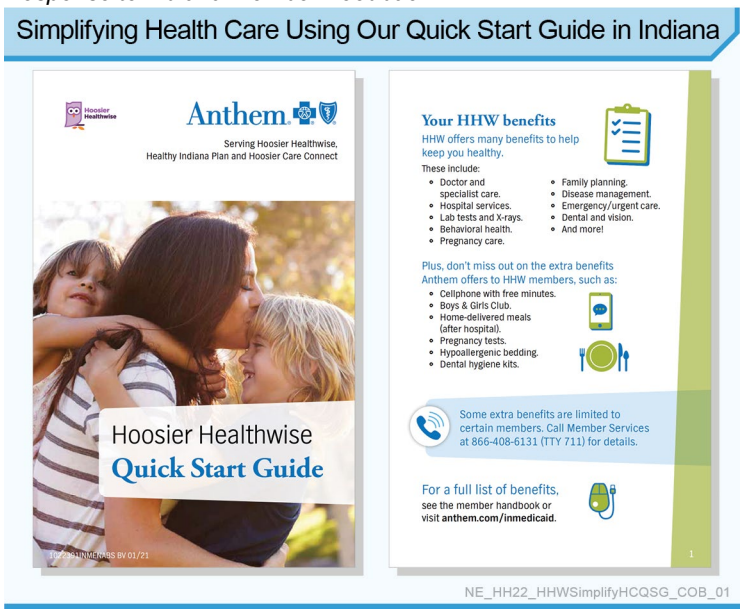
Example 4. Recommendations to Reimburse for Doula Services

In Q2 2022, the Health Education Advisory Council of our affiliate plan in Louisiana hosted a Maternal Health Disparities listening session. During this session, stakeholders encouraged the affiliate plan to consider the use of Doulas to improve birth outcomes. As a result, the plan developed a Doula pilot program intended to improve birth outcomes of Black members. The pilot program expands upon a long-time partnership with Community Birth Companion, a non-profit organization focused on reducing maternal and infant mortality. The Louisiana Doula program is a pilot to provide Doula support to members in targeted rural areas and reduce disparities affecting Black members. Community Birth Companion will train 10 Doulas and offer education and wellness support for up to 75 pregnant Healthy Blue mothers within a one-year span.

Example 5. Acting on Feedback to Create Concise Information About Plan Benefits

Members of the MAC in our affiliate market in Indiana made recommendations for the development of a brief and accessible printed collateral that newly enrolled members could use as an aid to quickly orient them to their new health plan. In response, the affiliate developed the ***Quick Start Guide*** *(QSG)*, shown in Figure V.M.75-2, an abbreviated version of our member handbook, which provides concise, engaging, and easy-to-understand key information about our affiliate's benefits. The QSG walks members through key initial steps following enrollment, such as selecting a PCP, scheduling a checkup, and completing the HRS, including the member incentives available for doing so. We offer this guide in English and Spanish on demand, and it includes simple information on covered benefits and enhanced services, how to access the provider directory, the benefits of preventive care, how to get needed prescriptions and other care, and how to contact us. Member feedback about this innovation has been very positive, and the QSG has been adopted as a best practice by our affiliates in other markets and will be included in our new member welcome packet for Nebraska members by early 2023.

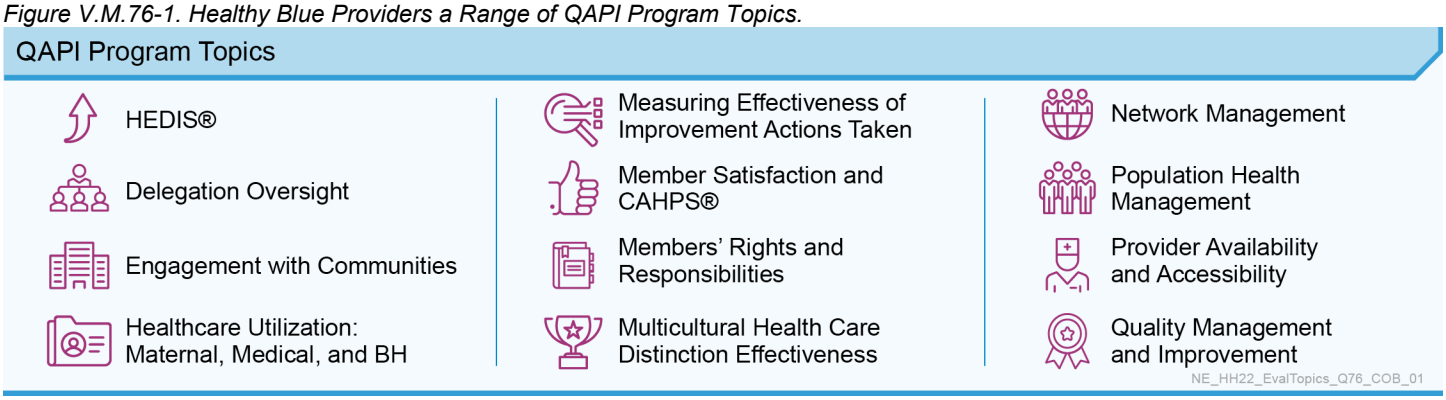
Figure V.M.75-2. We Created the Quick Start Guide (QSG) in Response to Indiana Member Feedback.



No. 76

Healthy Blue brings comprehensive member services, education, and communication strategies to support Nebraskans in taking charge of their health care and making informed decisions. We provide members and their families with timely, clear, accurate, and culturally relevant information to support them in making educated decisions about their health and well-being. Our communications increase member and provider awareness of the Quality Assessment and Performance Improvement (QAPI) program, as well as member health conditions and treatment options, provide education on the importance of preventive care, and engage members and providers through participation in our various programs. Any communications made available to members and providers will be sent to the MLTC for approval prior to distribution.

Figure V.M.76-1. Healthy Blue Providers a Range of QAPI Program Topics.

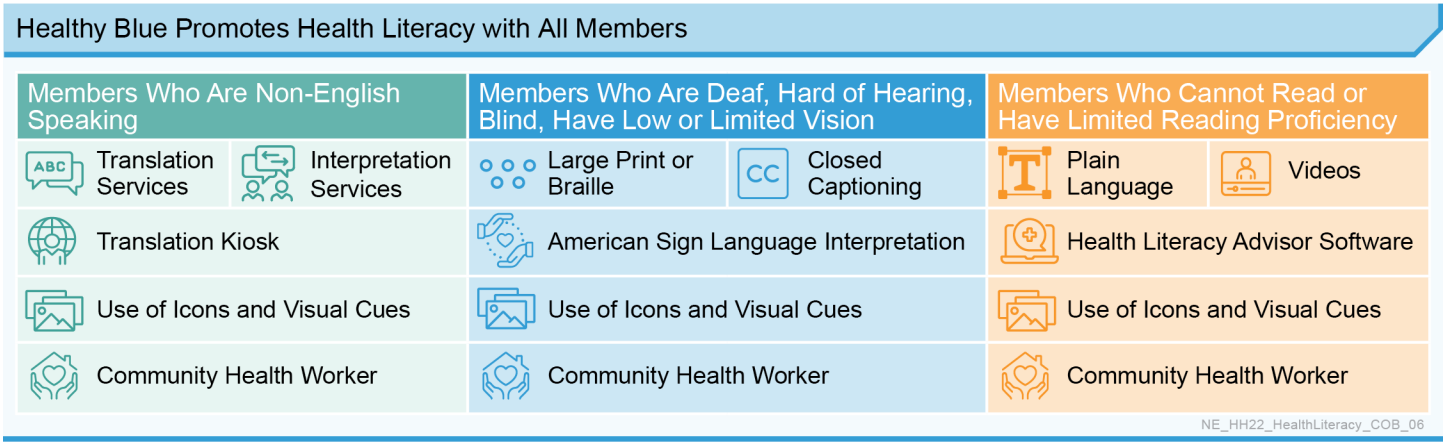


Information about Healthy Blue's QAPI Program is made available to members and providers on an ongoing basis. Our QAPI team, led by QM Coordinator Janet Endorf-Olson, develops education that is distributed to members and providers via multiple modes. Examples of QAPI topics communicated are provided in Figure V.M.76-1. For example, Healthy Blue assesses the impact and effectiveness of its QAPI program annually through an evaluation of performance against key quality performance indicators and the plan's objectives. Priorities are identified for the coming year. We evaluate this from a population perspective, looking at trends, outcomes, and access. We assess member's experience to determine if we are meeting their needs. We evaluate the overall effectiveness of our quality management/quality improvement (QM/QI) program and use those findings to determine the adequacy of the program design and resources. We share the results of this evaluation annually as part of our commitment to accountability and transparency to members and providers. MLTC will be provided all QAPI correspondence sent to members and providers as required in the SOW prior to distribution.

Providing Innovative Approaches to Assure Member Understanding of the QAPI Program

We develop communications that celebrate and appeal to the diversity within our membership and promote health literacy. We have established policies and procedures that assure all member communications go through our rigorous Collateral Materials Approval Process (CMAP) prior to use to make sure the material is clear, simple, accurate, and does not defraud, mislead, or confuse members or their families. We assure broad accessibility, comprehension, and understandability of our QAPI program by:

- Producing all member communications in plain language at or below a sixth-grade reading level, as verified by the Flesch-Kincaid readability formula and alternate formats and languages, including English and Spanish, including large print, braille, and auditory translation, upon request and at no cost to the member
- Representing varying ages, races, family structures, and abilities in our photography to make our messages more inclusive; and maintaining a library of continually updated proprietary photography to make sure we reflect diversity in our materials and working with vendors who employ ISO-certified translators for all non-English translations
- Accommodating varying levels of literacy and health literacy, through brevity and clarity in our materials
- Creating educational materials in video format, including welcome videos on topics such as appropriate use of the emergency department (ED)
- Making all video content available with closed captioning to improve accessibility for people with varying abilities
- Supporting ad hoc requests for communication assistance through our Concierge Unit and Member Services team, including reading communications over the phone
- Providing condition-specific information using interactive tools such as Sydney Health, and guidance for accessing QAPI programs



Member Approach

Healthy Blue deploys multiple methods, including distribution of information indicated in ***our member welcome packet and handbook, which includes a post-card providing information on Healthy Blue's QAPI program, information distributed via our member newsletters, and communications posted on our member website***. We summarize additional communication modes in Table V.M.76-1.

Table V.M.76-1. Healthy Blue Uses a Variety of Additional Communication Modes.

Communication Mode	Activities and Education
Text Campaigns	We use text message alerts to engage members in managing chronic conditions, encourage preventive care, help members stop smoking, and follow up with members after a BH hospitalization. In 2021, ***Healthy Blue has used texting to deliver 200,000 messages to more than 60,000 Medicaid members. More than 8,000 members texted back, with inbound messages most frequently received on well-child and well-adult campaigns.***
Sydney Health (Sydney)	Sydney is our digital member engagement platform consisting of a secure member website and mobile app. It is a powerful digital ecosystem with personalization at its core, providing a tailored experience to each member based on artificial intelligence and machine learning.
Member Advisory Committee	This committee promotes a collaborative effort to enhance Healthy Blue's patient-centered service delivery system. Its purpose is to allow members and providers to give input and advice regarding out QAPI program and policies.
In-person and Live Engagement	Members have multiple ways to reach us directly; for example, through our Welcome Rooms, Community Health Workers, community events and Member Appreciation Days, as well as face-to-face care management and outreach calls.

Provider Approach

We maintain a comprehensive provider communication strategy that allows us to engage and educate providers using accessible, evidence-based, and timely information; this is delivered through print, in-person, and digital modalities. ***Our strategy leverages our provider education resources and infrastructure, including Healthy Blue's Nebraska-based Provider Experience team, our web-based Medicaid Training Academy, our provider communication tools and supports, and ongoing outreach activities.*** We educate and train our providers across a comprehensive range of QAPI topics and learning goals that are important for assuring appropriate use of health care services, access to high-quality and equitable care, and improved population health for our Healthy Blue members. In Table V.M.76-2, we summarize communication and education modes.

Table V.M.76-2. Healthy Blue Reaches Providers Using a Variety of Communication Modes.

Communication Mode	Activities and Education
Provider Orientation and Onboarding	Our Provider Experience Representatives meet individual providers, provider groups, and cohorts of new providers in their office, at other location(s), or by remote video. Provider Experience Representatives present our provider orientation and onboarding, which provides an overview of the QAPI Program. Examples of topics discussed include overview of Healthy Blue's QAPI Program, member rights and responsibilities and cultural competency.
Provider Handbook	Our provider handbook is a comprehensive resource designed to inform providers of our program guidelines and requirements and to assist in caring for members. We review the manual with network providers during orientation.
In-person and Virtual Education and Collaboration Opportunities	Healthy Blue's QM and Provider Experience staff provide in-person and virtual provider education and collaboration opportunities through town hall events, meetings, and monthly webinars. These events are frequently tailored toward a specific provider type or topic, such as EPSDT and HEDIS® education. ***In 2022, we conducted 56 unique provider webinars, covering topics that included improving the patient experience, HEDIS training, and social determinants of health education.***
Provider Website	Our user-friendly provider website is a key way we deliver communications and educational resources. Access to trainings, toolkits, and QAPI program highlights are available at the provider's convenience. The website also provides provider bulletin alerts and access to our provider portal.
Provider Alerts (Fax, Email, and Provider Bulletins)	We send updates to providers via fax blasts, emails, and bulletins posted on our provider website. Provider bulletins communicate information about new state-initiated programs or updates, policy clarifications and updates, updates to our Provider Policies and Procedures Manual, and to reinforce current policies and procedures. We also use bulletins to distribute clinical protocols.
Provider Newsletter and e-updates	Our provider newsletter and e-updates contain relevant and helpful information designed to educate our network on QAPI program updates, member needs, and best practices. We post the newsletter to our provider website and alert providers by email when a new newsletter is available. Updates include updates such as clinical practice guidelines changes.
Clinical Advisory Committee (CAC)	Our CAC engages local physical health, BH providers, and providers representing the types of services our members receive. It reviews and provides input on QM activities and approves guidelines, program evaluations, and descriptions. The CAC assesses provider quality-of-care issues and discusses plans of action.

No. 77

Healthy Blue's Approach to Utilization Management (UM)

Healthy Blue has a successful, NCQA-accredited UM program that has demonstrated improved member outcomes. It is integrated with and supports our quality management priorities, including our population health program. It is aligned with the State's goals to advance evidence-based practices, health care service excellence, high-value care, and member health. Healthy Blue's UM program assures ***each member gets appropriate, medically necessary care and supports, where and when they need them***.

We employ an integrated and holistic UM approach that considers not only members' medical and/or behavioral conditions when making medical necessity decisions, but their home environment, family and caregiver supports, resources and social challenges, as well as the availability of services within the local delivery systems.

Our integrated UM leadership, under the direction of Tamara Mostek, RN, Case Management Administrator, and Tami DeBonis, RN, Medical Management Coordinator, has built collaborative relationships with providers and implemented processes to reduce provider burden while assuring quality care for members.

CALLED TO CARE

Tami DeBonis, Medical Management Coordinator

As a labor nurse and a former teen mother who relied on public support while in school, I am passionate about maternal health and supporting BIPOC, low income, and teen moms in getting the resources they need to have safe and healthy pregnancies. I am a strong advocate for our members and am currently working with a tribal member who suffered severe trauma and facilitated a great collaboration between Healthy Blue, DHHS, and the Winnebago Tribal Hospital team to secure services for this individual. In my free time, I have served on the Board of the Papillion Community Foundation and am currently working with their Urban Garden Project to provide fresh vegetables to local food banks.

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Our experienced staff identify additional member needs during UM reviews so they can make appropriate referrals to care management for complex outpatients and assure safe hospital discharges. Our Utilization Management Committee (UMC) leads daily operations and maintenance of our UM program with Healthy Blue leadership, who assure the development, use, and monitoring of clinical criteria and tailored guidelines to meet the unique needs of our members.

Our coordinated UM program assures members receive timely, appropriate care through individualized interactions and as applicable, care plans through which we integrate our support programs as well as a wide range of community resources. As part of our population health program, our ***care management strategy*** leverages transformational data analytics that proactively identify members with complex care needs and health disparities who could benefit from dedicated resources. Our Care Managers (CMs) assure their care is holistic and coordinated, address gaps and obstacles to accessing care, including identifying and linking members to social supports and interventions addressing social determinants of health (SDOH).

For our members who are hospitalized or in nursing facilities and have chronic or complex comorbidities and require more intensive or integrated services, our ***facility-aligned UM Clinicians*** collaborate with our physical health CMs and our dedicated behavioral health (BH) CMs to create a care plan that is aligned with appropriate programs and interventions. The UM Clinicians may conduct a face-to-face visit with the member in the inpatient of facility setting and include, when possible, the member's provider, family members, or others involved in the member's support system. For all members, in all circumstances, we consider the member's home and social support situation, particularly when the member is experiencing transitions of care.

Through our Clinical Advisory Committee, and multiple other venues through which we obtain provider feedback, we engage a range of providers in the review and approval of ***clinical practice guidelines and UM processes*** such as prior authorization (PA). Our ***automated, evidence-based tools*** expedite submission of requests and improve efficiency of determinations, including real-time authorization requests for some codes, decreasing provider burden, and improving timely access to needed care.

Healthy Blue's UM program improves clinical outcomes and drives process efficiencies in the delivery of care. As depicted in Figure V.N.77-1, in 2021, we consistently exceeded key care delivery metrics.

[redacted]

Innovations and Automation

Healthy Blue's innovations and automation support our staff in making accurate and consistent determinations, reduces administrative burden for providers, and streamlines our workflows to enhance outcomes for members.

[redacted]

[redacted]

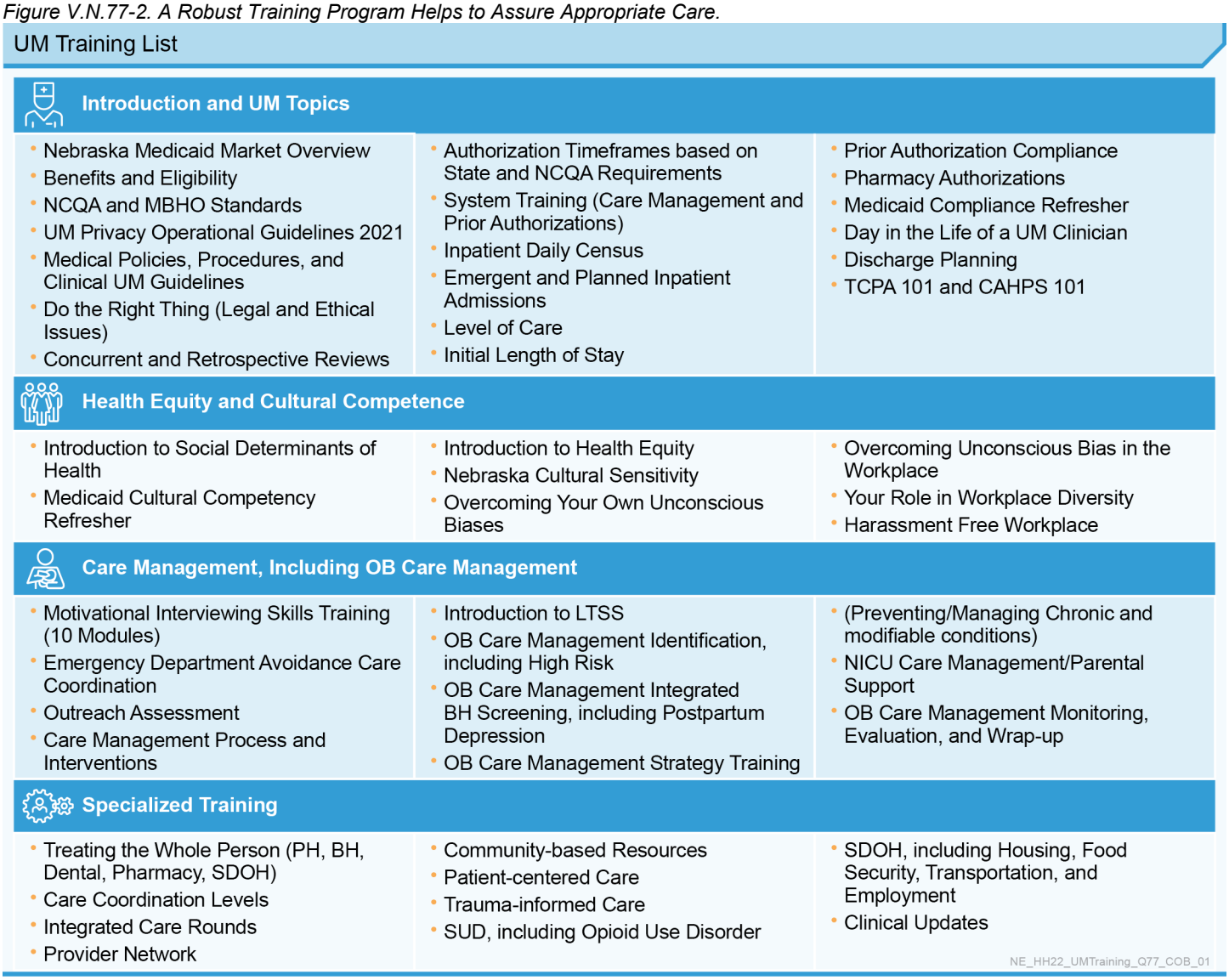
Accountability for Compliance with Utilization Policies and Procedures

Healthy Blue's comprehensive UM policies and procedures, systems, and experienced staff guide accurate and consistent application of clinical criteria for service authorization and concurrent and post-service reviews in accordance with our contract with DHHS.

Training of UM Clinicians to Assure Appropriate Compliance. UM Clinician training is a continuous process that begins the moment a clinician joins our team and help to assure consistent application of UM review criteria. We leverage a variety of training methods to meet the needs of adult learners with diverse learning styles to assure our staff can interpret and apply UM guidelines appropriately and consistently. Once our staff completes the initial training, we match every UM Clinician with a preceptor to provide ongoing support and guidance including skill practice scenarios with checkpoints.

In addition to specific UM clinical training, all UM Clinicians receive training on whole-person health (physical health, BH, LTSS, and SDOH). Figure V.N.77-2 details a listing of selected UM staff training opportunities. We assign trainings at regular intervals throughout the year via our internal Learning and Development platform. Healthy Blue is prepared to provide DHHS with a written training plan, including dates, subject matter, and training materials upon request.

Figure V.N.77-2. A Robust Training Program Helps to Assure Appropriate Care.



The UM team also incorporates a “Culture Commons” series into our monthly team meetings that models our parent company’s regular culture conversations involving leadership. Our goal in this is to promote a culture in alignment with enterprise values such as agility, and openness to change and growth.

Our Committees and Audits Assure Accountability. Our national Medical Policy and Technology Assessment Committee (MPTAC) — which includes physicians from various medical specialties, clinical practice environments, and geographic areas, as well as BH professionals — annually reviews and approves, and updates more frequently when appropriate, medical policy and clinical guidelines. This process involves soliciting input from the medical community. Healthy Blue’s Chief Medical Officer, Dr. Debra Esser, serves on our national Medical Operations Committee (MOC), which annually reviews, adopts, and approves documents related to UM policies and procedures, clinical guidelines, and Disease Management programs. ***To assure broader representation of practitioners with knowledge of the local delivery system, Healthy Blue’s UM Committees provide input, review, approve, and adopt medical necessity criteria used in Nebraska.*** We make UM criteria available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Plan Medical Director. We will continue to submit our UM program policies and procedures to DHHS for review and approval prior to making any substantive changes.

UM performance monitoring is a formalized function within Healthy Blue. Monitoring UM activities helps us identify opportunities for improvement that can lead to delivery of higher quality services, more efficient operations, and improved member and provider satisfaction. Our auditing processes identify the effectiveness of our UM Clinicians, physicians, and processes for medical necessity determinations. We assure UM clinical staff compliance with UM policies and procedures, adherence to our adopted criteria, and consistency and appropriateness of medical necessity determinations through our Inter-Rater Reliability (IRR) and Performance Improvement and Enhancement (PIE) programs. The Enterprise Clinical Support team independently and objectively conducts these audits.

Inter-rater Reliability Program

Healthy Blue utilizes an IRR program to assess the consistency and adherence to our medical necessity criteria by individual clinical reviewers. We conduct the IRR review at least annually and use NCQA-approved methods for auditing. All our clinical UM staff participate in the IRR process. We report results to the Chief Medical Officer, the Quality Improvement Committee, and the MOC. As depicted in Figure V.N.77-3, our IRR scores in 2021 exceed our benchmark of 90%, and we continuously identify opportunities for improvement and develop and implement action plans.

Figure V.N.77-3. IRR Scores Exceed Benchmarks.

We conduct NCQA-approved annual IRR audits of all Medical Directors and UM Clinicians to evaluate our consistency and accuracy in applying UM criteria, and to help us assure we are treating members and providers fairly and consistently in our delivery of covered benefits and services. The goals of our IRR program are to:

- Measure knowledge and appropriate decisions based on federal or State-specified criteria and Healthy Blue medical policies
- Minimize variation in the application of criteria
- Enhance staff recognition of potentially avoidable or inappropriate utilization
- Identify staff members who need additional training
- Identify potential risks resulting from inconsistent application of guidelines
- Have the knowledge and resources needed to identify potentially avoidable or inappropriate utilization, including potentially preventable admissions, readmissions, and emergency department (ED) visits

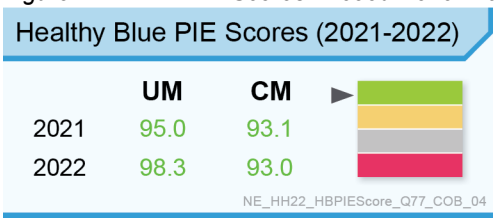
Our audit program uses hypothetical UM test cases or a sample of UM determination files along with a NCQA-approved auditing method. Medical Directors and UM Clinicians who do not meet the targeted standard are subject to a corrective action plan to bring their performance up to plan expectations. None of our Medical Directors has ever been under corrective action.

Performance Improvement and Enhancement Program

Our PIE program supports consistent application of review criteria for authorization decisions and continuously evaluates our UM program using monthly clinical (including physicians) and non-clinical staff audits (including call reviews). The program objectively monitors and evaluates the appropriateness, documentation, and quality of the services provided to members and helps to assure the consistent application of UM, and NCQA guidelines and processes. The UM case review includes evaluation of components within the following areas: timeliness, clinical review documentation, application of clinical criteria/guidelines for decision-making and appropriate case completion.

Our PIE Audits demonstrate that we exceed our benchmarks of 90% with high scores and an ***improvement*** in the UM PIE audit from 95% (in 2021) to 98.3% (in 2022) as depicted in Figure V.N.77-4.

Figure V.N.77-4. PIE Scores Exceed Benchmarks.



The PIE program includes the following components:

- The Clinical Audit program, which plays an integral role in driving performance improvement by continuously evaluating our UM activities. A key area of focus is adherence to new or updated processes and criteria to address areas of opportunity before annual IRR audit.
- The PIE Reporting team, which directly supports the work of the Clinical Audit Program by developing and issuing detailed monthly audit results reports that summarize the clinical audit findings, identify areas for improvement, and create enterprise trend comparisons that help our UM leadership prioritize necessary trainings or process changes. Healthy Blue shares the PIE audit results directly with the UM physician and their manager to act upon as appropriate.

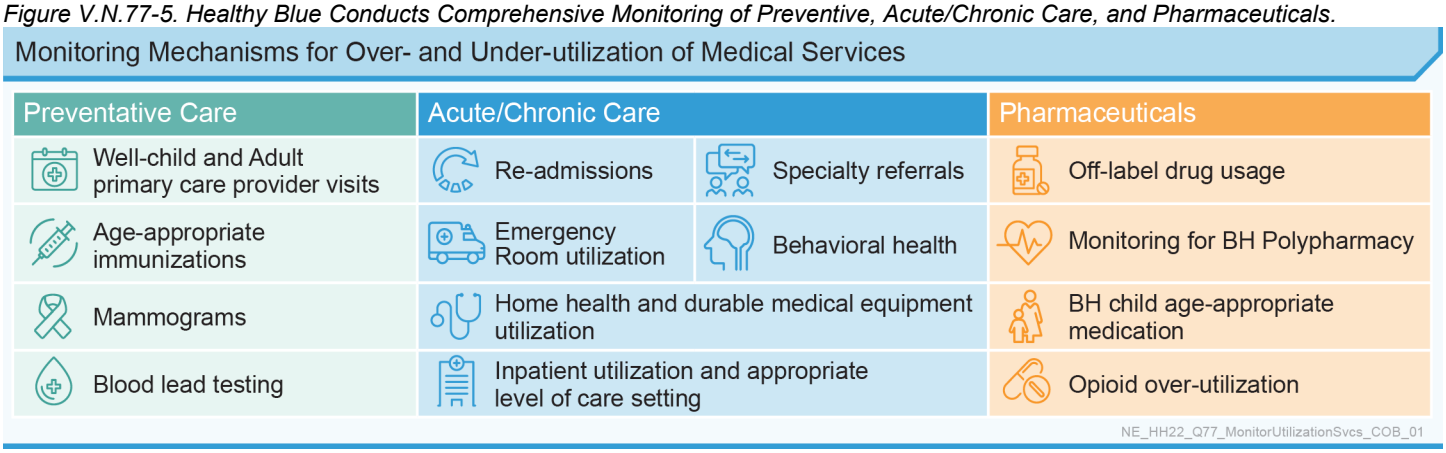
Audit Results Drive Improvement

We report individual performance and overall UM department IRR and PIE results to our lead Medical Director, UM Manager, UMC, and Quality Assessment and Performance Improvement Committee (QAPIC) annually as required. The audits identify staff who need additional training, as well as opportunities for new training modules or refreshers that would benefit the entire UM team. We also use results from these evaluations to identify opportunities for improvement to our processes and workflows, such as developing new training modules or requiring more frequent refresher training. We communicate changes in our processes to our UM team through the UM Manager during clinical supervision, intra-net communications, and ongoing and annual training. As part of our Delegation Agreement, we require our subcontractors with delegated UM authority to have electronic submission capabilities that meet our specifications.

Mechanisms to Detect and Document Over- and Under-utilization of Medical Services

Healthy Blue monitors our UM program to detect, document, and correct potential over- and under-utilization. We produce aggregated non-identifiable data utilization reports at a minimum on a quarterly basis. Monitoring is comprehensive and includes preventive care, acute/chronic care, and pharmaceuticals as indicated in Figure V.N.77-5.

Figure V.N.77-5. Healthy Blue Conducts Comprehensive Monitoring of Preventive, Acute/Chronic Care, and Pharmaceuticals.



Healthy Blue identifies under-utilization in preventive and disease-specific services through the monthly data runs of HEDIS metrics compared with national, regional, and internal benchmarks. We are especially vigilant about measures associated with EPSDT and other care opportunities for children, youth, and young adults served, as demonstrated through our Birthday Reminders program. As depicted in Figure V.N.77-6, ***our mechanisms to detect and address EPSDT under-utilization have driven improvement in related HEDIS rates***.

An example of Healthy Blue's focus on ED over-utilization is specific to two member populations: 1) those admitted to the ED and then discharged against medical advice; and 2) those who need a mental health (MH), or substance use disorder (SUD) appointment with seven days of discharge from the ED. For both member populations, we contact those members regardless of participation in care management. [redacted] Following our care coordination processes, we assess the member for current needs and help them get needed follow-up appointments. We also review with the member alternative services available to them, such as: PCPs, specialists, urgent care, telehealth, our 24-hour Nurse Helpline, crisis centers, transportation services, our Healthy Rewards program, interpretation and translation services, case management services, Safe Link, food resources.

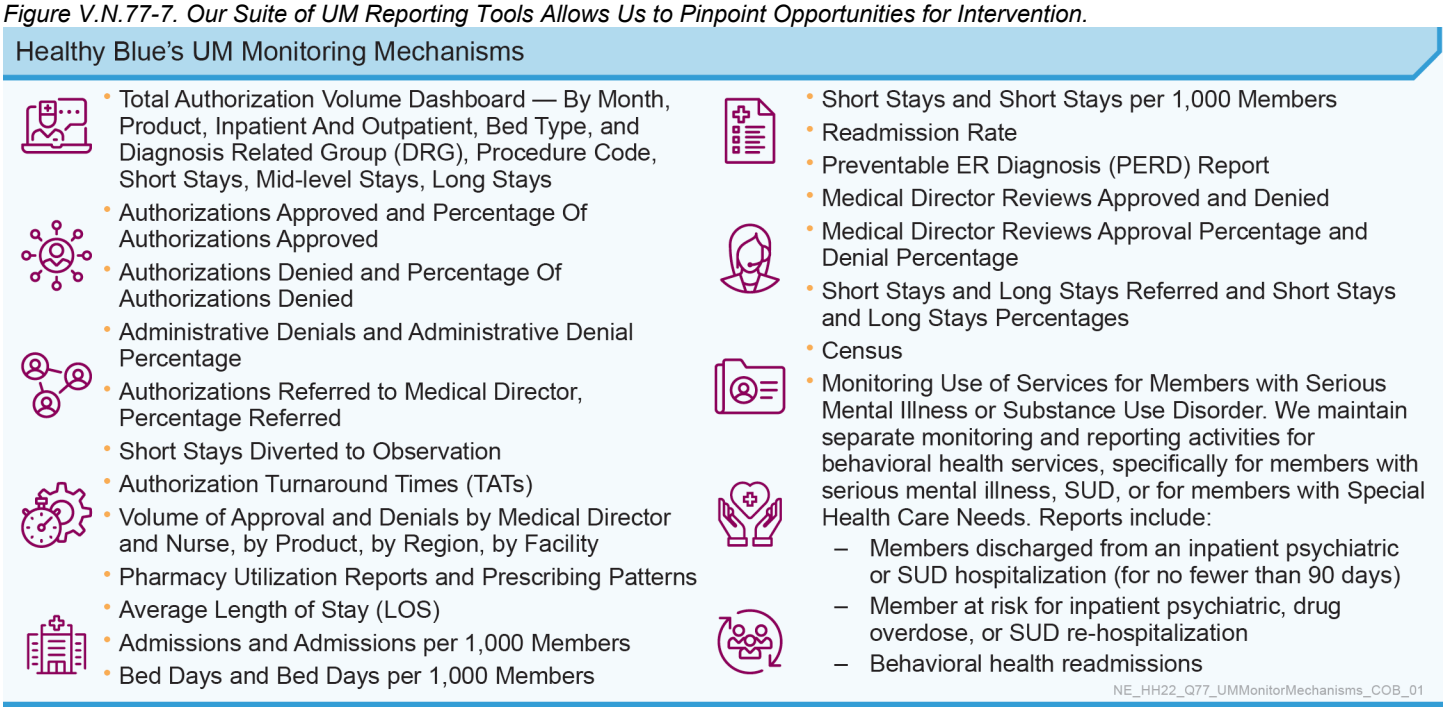
Our UM approach incorporates MH and SUD into all our processes, and we take into consideration those with complex MH or SUD when making medical necessity determinations. Our multi-disciplinary teams meet regularly to review PAs and discharge planning documents to assure integrated care for our members. For example, through our Restricted Services Committee***, we identify members above the State's opioid daily maximum and coordinate with our Care Management team and the prescribers to assess appropriate use and reduce risk by using opioid alternatives and/or coordinating between multiple prescribers***.

To address soaring BH exacerbations during the COVID-19 pandemic, Healthy Blue implemented additional strategies to help manage BH conditions of our members. We adopted a unique program that flags members who are late filling their prescriptions for critical MH medications and assigns these members for calls to check on their medication and any other issues they may need help with, and we also expanded our BH telehealth offerings [redacted]

UM Dashboard and Other Monitoring Mechanisms

Leveraging Healthy Blue's robust UM dashboard, our UM staff review authorization data to identify opportunities to increase appropriate utilization and decrease over-utilization of services. For example, our dashboard enables us to pull reports on short stays and clinical observation unit diversion, which helps us monitor the utilization of appropriate level of care setting, and make sure our members are not admitted to an inpatient setting when it is not clinically appropriate. Our suite of utilization reporting tools helps us look for opportunities to direct members to appropriate utilization, identify gaps in the network, and pinpoint opportunities to improve communication with our providers. Healthy Blue's UM program uses several monitoring mechanisms as depicted in Figure V.N.77-7.

Figure V.N.77-7. Our Suite of UM Reporting Tools Allows Us to Pinpoint Opportunities for Intervention.



Additionally, we use the Member 360°$_{SM}$ platform to flag gaps in care. To address gaps, our Care Management team reaches out to members to focus on preventive care and self-management support, and to assist with connecting the member back to their PCP. When necessary, our Clinical staff collaborate with the Chief Medical Officer to review intervention strategies targeted at enhancing appropriate member utilization practices and provide member intervention as appropriate, including care management.

A Medical Director and Provider Experience Representative review providers identified as having significant aberrant patterns of utilization to determine actual utilization of services. The PER, in collaboration with the appropriate Medical Director, develops a performance improvement plan and discusses the plan with the provider, and improves outcomes through technical assistance and training. Our Special Investigations Unit (SIU) is engaged if waste, fraud, or abuse is of concern. We continue to monitor and trend the utilization patterns of identified members and providers and after a six-month period, or earlier as indicated, the Healthy Blue or Regional Medical Director or designee performs a review of the provider's performance. We employ routine methods for addressing provider continuance of inappropriate utilization.

The UMC reports findings and recommendations to the QAPIC regarding provider performance, trends that indicate quality-of-care concerns, aberrant utilization trends, adverse access patterns, and lack of coordination of care. During QAPIC meetings, a multi-disciplinary team reviews this information and takes corrective actions to address identified issues.

Development and Regular Reviews of Utilization Review Criteria

Our national MPTAC serves as our official medical and clinical policy-making body in the development of clinical standards or review and adoption of nationally recognized standards, to support evidence-based coverage policies. MPTAC presents approved medical policies and clinical UM guidelines to the MOC for adoption and to assure consistency and a standardized process. MPTAC responsibilities include evaluation and recommendations of revisions to existing UM decision-making guidelines, adoption of new criteria, and assessment of new medical procedures and technologies for incorporation into our guidelines. As described earlier in this response, to assure representation of practitioners with knowledge of the local delivery system, Healthy Blue's UM Committees provide input, review, approve, and adopt criteria and any revisions to criteria used in Nebraska.

Healthy Blue uses nationally recognized, evidence-based guidelines including MCG Care Guidelines and the American Society of Addition Medicine (ASAM). MCG Care Guidelines support care coordination across the continuum of care, such as inpatient and outpatient reviews, concurrent reviews, and rehabilitation. We use non-customized MCG Care Guidelines uniformly for all populations, in particular acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute facility, and BH inpatient. ASAM provides BH clinical guidelines for the treatment of SUD including opioid use disorder (OUD). We use additional national guidelines produced by reputable health care organizations such as individual medical and surgical societies, the National Institutes of Health, and the Centers for Disease Control and Prevention. We also solicit input from the medical community.

We keep our member at the center of every UM decision. Our UM program considers multiple complex factors when authorizing services, matching criteria to the member's current condition, severity of illness, comorbidities, and episode-specific variables. We strive to deliver a flexible, provider friendly, efficient, and fiscally responsible program. We also consider the member's home situation and may consider options like mor days in treatment, inquiring about transfer to lower levels of care, including services in the home, based upon clinical need to assure safety and support for the member. For our members who are in the hospital or have chronic or complex comorbidities and require more intensive or integrated services, our UM Clinician collaborates closely with the CM to increase the intensity of integration of care and reflects this in the member's care plan.

Determination and Reevaluation of Which Services Require Prior Authorization

Our national Clinical Solutions team works with our national MOC to perform annual reviews of services requiring PA. They determine whether changes would simplify processes for members and providers without compromising care and evaluate the need for any new PA requirements in alignment with State policies. Our Clinical Solutions team draws from evidence-based study outcomes and enterprise best practices to make recommendations for changes in PA requirements for services for our region. Healthy Blue considers these recommendations and listens to providers concerns across all lines of business when considering PA requirements in Nebraska. We summarize feedback from providers and input from providers serving on our committees for our Provider Experience Representatives and the State, and we identify opportunities for improvement. For example, based on provider input, we changed OB ultrasound policy to include first two scans without PA. We also respond quickly to any State requests for modification to PA requirements. Based on recommendations, our UMC makes determinations and provides final approval on the adoption of PA requirements for Nebraska.

Determination of Prior Authorization Requirements

Since 2019, we have reevaluated and eliminated selected PA requirements in Nebraska when we determined they would pose an unnecessary barrier and deter access to an important health care service. Healthy Blue adopted PA policies that allow for direct member access to the following services:

- PCPs
- Specialty care providers: We encourage members to use their PCP to coordinate specialty care, but we do not require referrals if the specialist is in network
- Emergency or post-stabilization services with out-of-network providers
- Outpatient BH or SUD services: Members may directly access routine, outpatient BH/SUD services
- Family planning and OB-GYN providers and some services as long as the OB-GYN is in network
- Adult annual wellness exam and well-child visits for members under 20 years of age
- Routine vision care
- Urgent care

While our clinical criteria are objective and provide a rules-based system for determining medical necessity (prospectively, concurrently, and retrospectively), our UM Clinicians understand there are always unique, patient-centered circumstances that factor into our decisions. We evaluate application of our criteria based on individual member needs and preferences, an assessment of the availability of services within the local delivery system, and the treating provider's request. We also consider community-based supports and services to make sure we do not duplicate services.

Reevaluation of Prior Authorization Requirements

Healthy Blue reviews and updates UM criteria annually and more often when utilization trends require review or revisions. Maximizing the delivery of appropriate services and minimizing occurrences of over- and under-utilization is a primary function of our UM program. We adjust clinical practice guidelines upon review of clinical indications for new medical services or procedures and new uses of existing services or procedures. Through a formally scheduled process, Healthy Blue reviews and develops medical policy and UM guidelines, as necessary. In addition to our annual review, we monitor over- and under-utilization reports and PA approval rates to identify opportunities to update our list of services that require PA. On a quarterly basis, we review PA requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our list of services that require PA and incorporate them into our QAPI program.

We use a variety of mechanisms to identify services we believe no longer require inclusion on the standard authorization list for medical necessity determination, including:

- **Data Mining.** We review PA requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our list of services that require PA.
- **Provider Collaboration.** We obtain provider input specifically to help improve our PA processes and identify PA request requirements that are inefficient or unnecessary.
- **Provider Feedback.** We obtain regular provider feedback through our MAC, peer-to-peer discussions between providers and our Medical Directors, as well as quarterly and annually through our provider satisfaction surveys. For delegated UM, we monitor provider and member grievances, appeals, and UM trends through regular delegation oversight meetings.

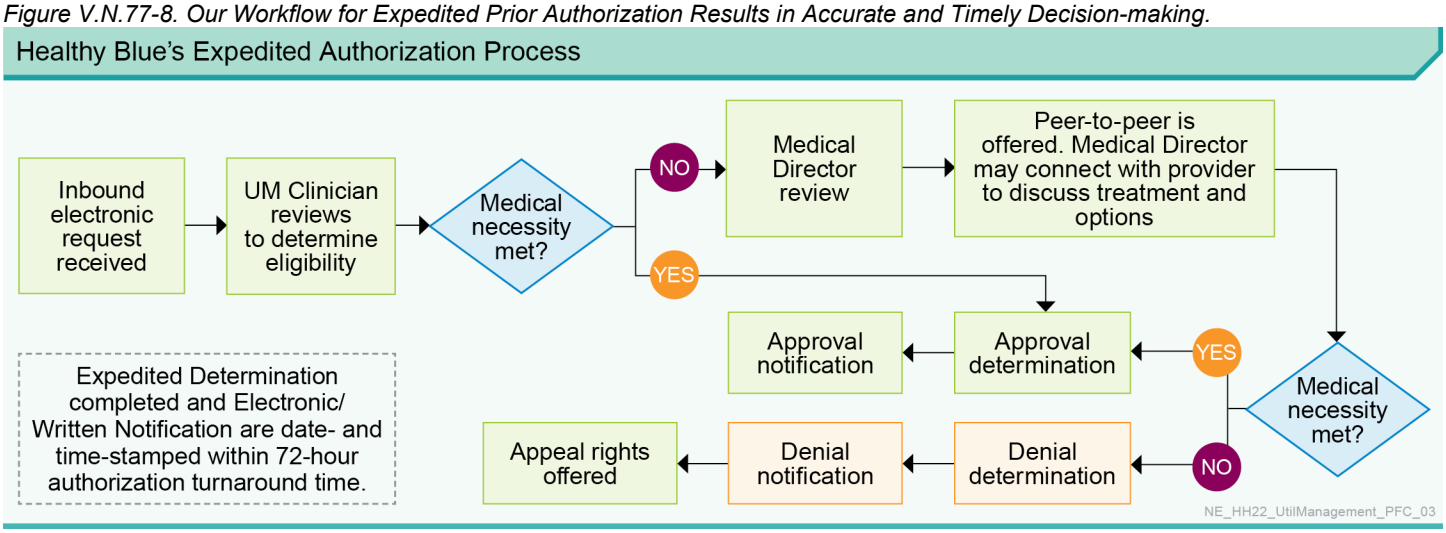
Prior Authorization Processes for Members Requiring Services from Non-network providers

Non-network providers typically seek an out-of-network authorization. Our UM team reviews and approves the request as appropriate, and we reimburse at 90% of the Medicaid fee schedule for all non-participating provider types. When the provider is out of state or requesting a negotiated rate, our UM team reviews the PA request and if approved, our Network Management team confirms validity and consistency amongst the systems. This includes a review of the Nebraska Medicaid Fee Schedules as well as the single-case agreements (SCAs) in our historical repository for payment purposes. Once Network Management completes their research, we outreach to the service rendering provider to agree on a rate.

Proposed Processes for Expedited Prior Authorization

Figure V.N.77-8 depicts Healthy Blue's expedited authorization process. Where the member's health condition requires an expeditious determination, we make decisions within 72 hours or sooner if the condition requires it, for example, if the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The standard is that of a "prudent layperson" who reasonably believes that the condition is of such a nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. While we may communicate the notification orally, we do not leave this information in a voicemail message. For urgent care decisions, the treating practitioner can be the member's authorized representative in seeking approval. Extensions of this timeframe are acceptable upon a member's request or if it is in the member's best interest.

Figure V.N.77-8. Our Workflow for Expedited Prior Authorization Results in Accurate and Timely Decision-making.



In addition, there is an expedited appeal process to accommodate clinical urgency of the situation. Each type of appeal request has a different timeframe for completion of the appeal process. All timeframes begin with the request for an appeal, even if the appeals department does not receive the request, and end with issuance of the determination. Unless federal Medicaid (CMS) or the State mandates otherwise, Healthy Blue's standard timeframe for appeals is within 72 hours of receipt of the appeal request. Oral notification is appropriate for non-urgent preservice, post-service and expedited appeals. We notify members of any delay and resolve appeals as expeditiously as the member's health requires. For expedited appeals, Healthy Blue may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner.

Continuous Refinement of Our UM Program

Every year, Healthy Blue conducts a UM program evaluation, which includes operational performance, clinical quality results, and member and provider experience outcomes. As depicted in Figure V.N.77-9, we strive to continuously improve our processes through data review and trending; refining criteria, guidelines, and processes; member education; and provider technical assistance, training, and consultation.

Figure V.N.77-9. Healthy Blue Continuously Establishes, Monitors, and Reviews Processes for Ongoing Refinement of Our UM Program.

No. 78

Healthy Blue's Utilization Management Program

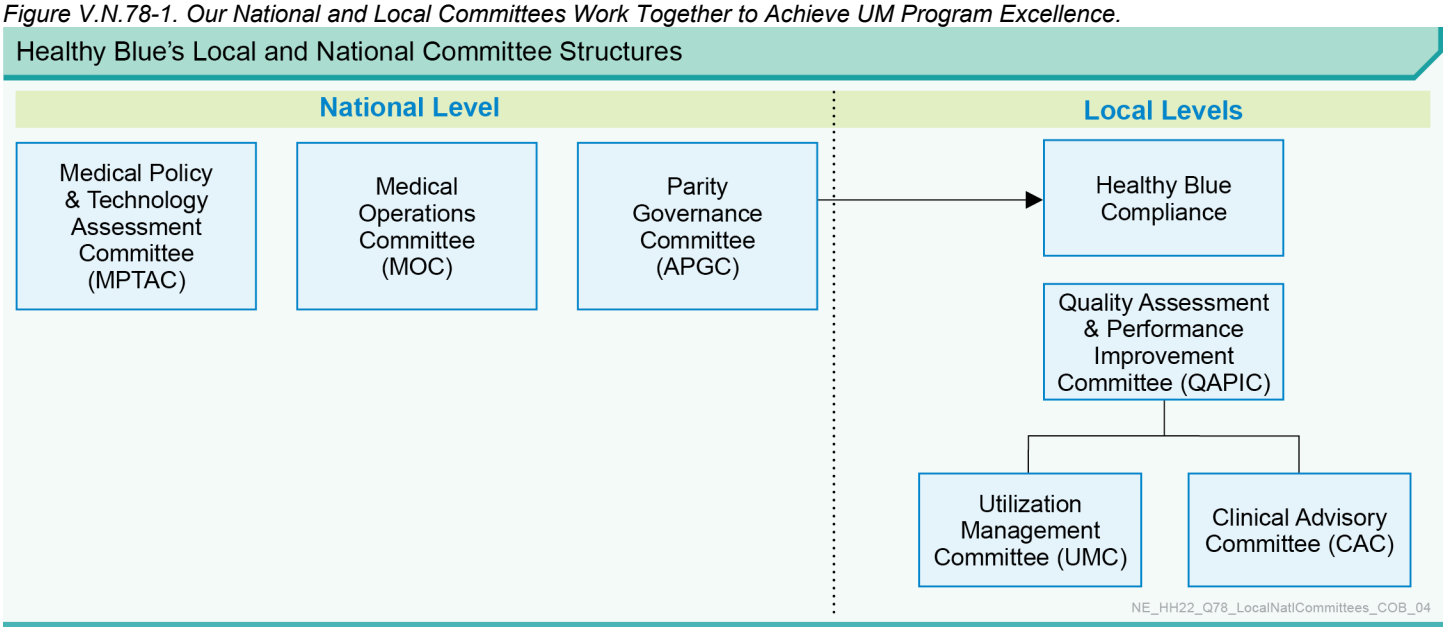
Healthy Blue has a successful, NCQA-accredited utilization management (UM) program that has demonstrated improved member outcomes. It integrates with and supports our quality management priorities, including our population health program, and aligns with the State's goals to advance evidence-based practices, health care service excellence, high-value care, and member health. We assure that each member gets appropriate, medically necessary care and supports, where and when they need them.

Our UM Committee Structure Leverages National Expertise and Local Knowledge

Healthy Blue's UM program derives great value from our enterprise-wide Office of Medical Policy and Technology Assessment, which is charged with developing enterprise medical policies and clinical UM guidelines for review and approval by our national Medical Policy and Technology Assessment Committee (MPTAC). MPTAC — which is composed of physicians from various medical specialties, clinical practice environments, and geographic areas, as well as behavioral health (BH) professionals — annually reviews and approves, and updates more frequently when appropriate, medical policies and clinical guidelines. ***In 2021, MPTAC reviewed and approved 166 established UM guideline, revised 65 UM guidelines, and developed 10 new UM guidelines adopted by Healthy Blue's Utilization Management Committee (UMC) and Clinical Advisory Committee (CAC).*** Our national Medical Operations Committee (MOC) annually reviews, adopts and approves documents related to UM policies and procedures, clinical guidelines, and Disease Management programs. ***To assure representation of practitioners with knowledge of the local delivery system, Healthy Blue's UMC and CAC provide input, review, approve, and adopt policies and procedures including service authorization procedures used in Nebraska.***

Our Senior Leadership supports a culture of continuous quality improvement and are members of our Quality Assessment and Performance Improvement Committee (QAPIC), which includes Chief Executive Officer (CEO), Rob Rhodes, MD; Chief Medical Officer, Debra Esser, MD; our Quality Management Coordinator, Janet Endorf-Olson, RN; Health Equity Director, Tiffany White-Welchen, LIMHP; and leaders for Population Health, BH Services, and Provider Solutions. The QAPIC also includes members from the community and network providers. Dr. Esser and Janet Endorf-Olson oversee the QAPIC, which provides multi-disciplinary and cross-functional direction and oversight of all QAPI and population health initiatives. Figure V.N.78-1 depicts Healthy Blue's national and local UM Committee structures and their relationship. The QAPIC oversees the development, approval, implementation, monitoring, and evaluation of the QM Improvement Work Plan and program document, complying with requirements mandated by DHHS, NCQA, and other related entities. The QAPIC collaborates across departments on solutions to remove barriers for Nebraska Medicaid members.

Figure V.N.78-1. Our National and Local Committees Work Together to Achieve UM Program Excellence.



Both the UMC and CAC report directly to the QAPI Committee and ensure coordination with the population health and QM programs. The population health and QM workplans integrate data and recommendations from the UMC and CAC pertaining to the outcomes of the clinical and service quality improvement studies. This includes a deep dive review of utilization data and what it reveals about the impact and effectiveness of Healthy Blue's service authorization procedures on access, quality, and protecting against under- and over-utilization. ***The collaboration between the UMC and CAC helps to ensure local recommendations are considered in the development of UM policies and procedures.***

Healthy Blue's UM Committee Assures Appropriate, Medically Necessary Care

Chaired by our Chief Medical Officer, Debra Esser, MD; and our Director of Medical Management Coordinator, Tamara Mostek, RN, our physical health/BH UMC oversees all UM and SDOH program activities and processes, including delegated clinical services.

The committee reviews, monitors, and evaluates UM program compliance with Healthy Blue standards, State and Federal laws and regulations, contractual requirements, and NCQA standards. As depicted in Figure V.N.78-2, the UMC ***monitors the program's overall effectiveness***, including for example, over- and under-utilization of health care resources such as long-term inpatient stays, grievances and appeals related to UM activities, and develops action plans for improvement. The UMC ***reviews*** the annual UM and

population health management program descriptions, evaluations, and work plans; policies and procedures; and workflows. Leveraging these data and information, the UMC ***establishes*** workgroups to analyze and make recommendations to improve the effectiveness of the clinical programs including, for example, measuring the outcomes of clinical improvement studies, and program improvement plans related to audit results. Our Dental UM Committee will be up and running by contract execution.

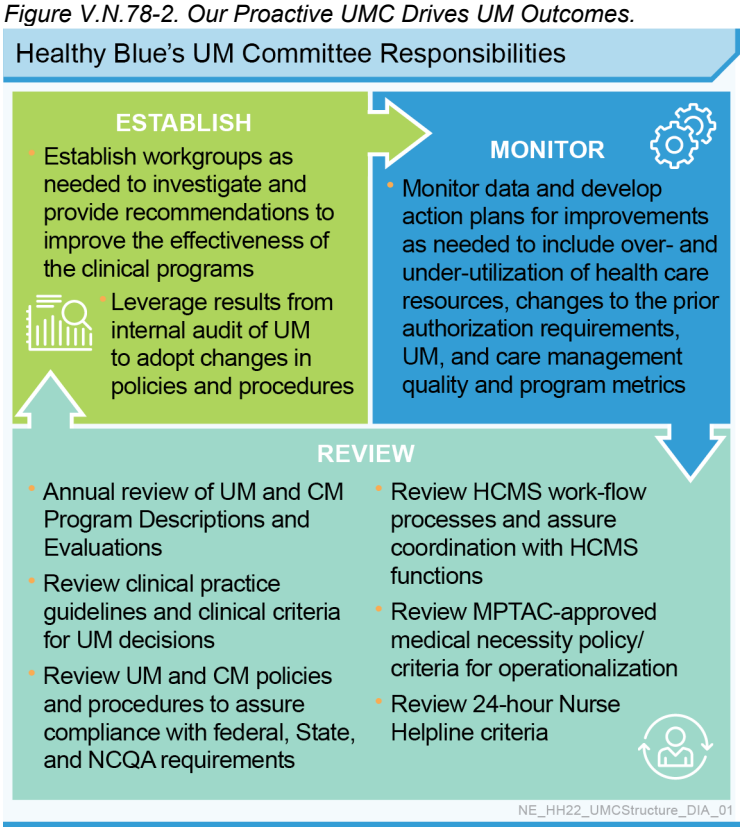
Our UMC meets quarterly, reports to the QAPIC and provides a quarterly written report to the QAPIC, which includes a summary of the QM-related activities, needs, and recommendations. The UM Committee is supported by robust analytics, which includes a standard set of reports produced by the clinical analytics team, including, for example, Preventable Emergency Room Diagnosis (PERD); Average Length of Stay; and a detailed report on Total Authorization Volume Dashboard by Month.

Our UMC is a proactive committee that engages continuously in quality improvement activities, evaluates opportunities to increase inter-departmental collaborations across quality and utilization improvement activities, reviews the Multicultural Health Care and Linguistic program, and assures practitioner involvement, including through direct input from the CAC.

Voting members of the UMC include the Chair and Chief Medical Officer and the following Healthy Blue leadership positions:

- BH Clinical Director
- Contract Compliance Officer
- Quality Management Coordinator
- Case Management Administrator
- Quality Management Coordinator
- Medical Management Coordinator
- PH UM Manager
- BH UM Manager
- Pharmacy Director
- Dental Director
- Network Management Director

Figure V.N.78-2. Our Proactive UMC Drives UM Outcomes.



Additionally, the committee may request attendance of staff from the different teams, including leadership and staff from the NCQA accreditation team, UM/care management data analytics, quality management, provider relations, and the call center.

The CAC Engages Network Providers in Developing Service Authorization Procedures

Healthy Blue's approach to the adoption of service authorization procedures is collaborative, integrates a holistic service model that includes both physical and behavioral health; incorporates input from network providers and internal leadership across quality, UM, and CM; and meets NCQA standards. While the UM Committee is responsible for service authorization procedures and their ultimate approval, our CAC serves a key role in providing input on these procedures as the CAC engages a broad range of external providers.

Our Chief Medical Officer, BH Clinical Director, Pharmacy Director, and QM leaders are internal representatives to the CAC. External representatives include seven network physicians and a nurse practitioner representing physical health (family medicine, internal medicine, OB-GYN) and BH providers (psychiatry) across Nebraska who care for children, adolescents, and adults representing diverse race/ethnicity and rural/urban members. ***A critical aspect of the CAC's role in the development of service authorization procedures is to communicate directly with and solicit feedback and recommendations from our network providers.*** They obtain and interpret provider feedback and recommendations for developing service authorizations and provide a venue for direct provider feedback and establish the process for responding to provider concerns.

Provider feedback through the CAC and other methods, Healthy Blue has changed policies, re-written guidelines, and adapted service authorization procedures to better meet provider needs. For example, based on CAC and network provider input on denials for pregnancy ultrasound, we changed our ultrasound policy to include the first two scans without prior authorization,

included home sleep studies in our scope, provide coverage for additional lab tests, and changed policies to cover bilateral surgeries.

The CAC also routinely conducts peer review processes for monitoring care quality, appropriateness, and treatment utilization, and they also develop provider training and solicit provider feedback on education and training opportunities. to assess provider quality-of-care issues and discusses plans of action.

No. 79

Establishing Appropriate Clinical Practice Guidelines

At Healthy Blue, we believe that the provision of quality health care expands beyond the treatment of injury or illness or managing chronic conditions. With oversight from ***Healthy Blue's Chief Medical Officer, Dr. Debra Esser***, we have solidified provider collaboration and engagement in the selection, development, and review of our CPGs. We are committed to helping providers and members become more proactive in the quest for better overall health and maintaining wellness. Since the inception of our first Nebraska Medicaid contract in 2017, we have worked collaboratively with the MLTC, providers and members to develop and adopt standard best practices that serve as our clinical practice guidelines (CPGs). We have used evidenced-based practices (EBPs) to frame our clinical policies and processes, and EBPs are based on the best valid and reliable national and state-specific research and evidence available. Additionally, these guidelines are jointly developed incorporating local provider and stakeholder knowledge and feedback, internal clinical expertise, and member preferences to assure guidelines and practices continually align with members' whole-health needs. Our collaborative approach promotes provider input, adoption, and buy-in to clinical standards and requirements. This results in the delivery of consistent, quality care that positively affects outcomes by assuring consistent application of CPGs by providers in our network to improve care outcomes.

We adopt CPGs that comply with state and federal guidelines both locally through our local Clinical Advisory Committee (CAC) in Nebraska and through our national Medical Policy & Technology Assessment Committee (MPTAC). MPTAC is a multi-disciplinary group that includes practicing physicians and academics from various specialties, clinical practices, and geographies. Our Medical Directors request specific guidelines or topics to be considered for approval on the CPG list. In addition, external providers can request that a guideline be considered, such as in Quality Assessment and Performance Improvement (QAPI) and Dental QAPI meetings. CPGs are then reviewed by the CPG Workgroup, which includes both physical health and behavioral health (BH) Medical Directors and presented to our national Medicaid division committees for review and approval. Healthy Blue's Quality Management (QM) Coordinator coordinates with our local CAC to review and approve adopted/revised CPGs and make sure they are consistent with and appropriate for Medicaid members. Our Medical Directors, who live and work in Nebraska, review all guidelines annually. To assure consistency, the CAC and MPTAC review provider and member education materials, benefit plans, and coverage parameters annually against guidelines. We continue to partner with other MCOs and the MLTC to confirm consistent application of CPGs, including ***the Nebraska Association of Medicaid Health Plans, which is collaborating on improving birth outcomes with a focus on provider performance against maternal CPGs. During this collaborative, we leverage the opportunity to discuss policies and procedures, including CPGs and EBPs, with other MCO leaders.*** We examine current CPGs in concert with those promoted by other Nebraska MCOs to identify discrepancies and build consensus and alignment across MCOs. Our nationally recognized clinical guidelines support our utilization management requirements by keeping us and our providers informed about scientific advances, supporting consistent care delivery, and positively impacting health outcomes. Using best practice guidelines, utilization, and health outcomes data, we modify our authorization process and benefit limits to advance member health outcomes. We recognize providers are actively engaged in patient care and aim to be certain they have regular, ready access to CPGs.

Providers are an integral part of addressing members' whole-health needs and making sure that practice guidelines reduce health disparities, are culturally competent, and reflect the needs of the communities in which we serve. With oversight from Healthy Blue's Chief Medical Officer, Dr. Debra Esser, we have solidified provider collaboration and engagement in the selection, development, and review of our CPGs. We engage providers across the state — including rural and urban providers with primary care, BH, specialty services, and facility-based expertise — to obtain their invaluable input on CPG adoption. Providers participate in CAC, Joint Operating Committee meetings, and the Provider Advisory Committee, along with additional enhanced communications and peer-to-peer consultations, to discuss adoption of CPGs as well as the proper application of CPGs.

Our CPGs contain EBPs that complement the providers' professional judgment in delivering the best possible care to members based on their unique needs and are the framework of our clinical policies and processes. EBPs are based on the best valid and reliable national and state-specific research and evidence available, including published medical evidence and clinical expertise. We make sure that CPGs include guidelines to address children with serious emotional disorders and adults with severe and persistent mental illness. This results in the delivery of consistent, quality care that positively affects outcomes by assuring consistent application of CPGs by providers in our network to improve care outcomes.

Considering the Needs of Our Members

We acknowledge the needs of members are diverse, and each member is unique. We are committed to improving the quality of health care for multicultural populations and assuring complex care needs are met through coordinated care plans. We use every interaction with members to identify their needs through face-to-face conversations with Care Managers, advisory groups, member listening sessions, community health workers, and calls made to our member services line. Additionally, we use retrospective analysis and predictive modeling to identify member's needs. We continuously collect multiple forms of data, such as claims analysis, demographic information, utilization, member experience, and social determinants of health data sets, to help identify medical and BH aspects of care or service performance that inform and prioritize our CPG development and adoption. Through data sources such as grievance and appeal, member CAHPS® results, utilization data, and advisory committee feedback, we monitor multiple aspects of member experience, which we use to determine member needs, barriers, and development of interventions. Through careful analysis of data, we can track trends in member experience and use the data to better inform and shape CPGs. Data are tracked on a continuous basis, and opportunities for improvement are identified through root cause analyses. When opportunities are identified, we apply appropriate changes to workflows and updates to the CPGs. In doing so, we are better able to analyze and adjust our CPGs to be certain the voices of members are incorporated in our CPGs. Additionally, in compliance with 42 CFR § 438.236(c), we make sure that we disseminate practice guidelines to members and their caregivers. CPGs are part of our member handbook and our member website. We educate members about CPGs during interactions and educate providers on the importance of discussing CPGs with their members.

Notifying and Monitoring Providers

We recognize providers are actively engaged in patient care and aim to assure they have regular, ready access to CPGs. In addition, we offer ongoing education and training for providers on recommended EBPs through tools such as our secure online portal, which offers quick access to clinical tools, member data, and health plan information. Availity, our tailored provider portal, simplifies provider

transactions, such as electronic data exchange, prior authorizations, claim status, and member inquiries. It provides a custom learning center, education, and a reference center that assists providers with up-to-date CPGs and EBPs. Providers also have access to data repositories such as EPSDT screenings and participation rates, regular updates to our provider website, email and fax blast communication, and a monthly newsletter. In addition to CPGs, we know that EBPs have a direct impact on health outcomes and make sure our providers are educated on and have easy access to recommended EBPs. We also know that education is the first step in provider engagement. Through our Training Academy and direct outreach, we make sure providers are educated on, have access to, and incorporate recommended EBPs into their clinical practices. Examples of EBPs we provide education on include Screening, Brief Intervention and Referral to Treatment; trauma-informed care; Medication-Assisted Treatment; and Person Centered Thinking© by the Learning Community for Person Centered Practices training. We actively engage our providers, seek their feedback, work collaboratively with them, and gain their buy-in. Through continuous data monitoring and analyses, we can quickly and directly address problems with providers as they arise. When providers want to submit additional literature in support of a practice change, we are able to connect them with the MPTAC, which collaborates directly with provider and physician groups to review additional literature, recommend changes, and explain the robust evidence behind our CPGs. We know that direct and bidirectional communication with our providers is essential to ongoing engagement, and ultimately the adoption and support of mutually established CPGs. We identify, initiate, and develop provider relationships and invite ongoing feedback through personal contacts that include:

- **Provider Experience Team.** This team is supported by our clinical staff and follows up on performance scorecards, dashboard reports, and custom data analyses that identify providers with opportunities for improvement. This may include identifying barriers the provider may be experiencing in adhering to CPGs, providing technical assistance to access CPGs on our provider portal, and sharing information on opportunities for the provider to give feedback on our CPGs. For example, when we identify a trend that these members are not participating in nutritional counseling, we send out a notification to our pediatricians to remind them of the guidelines, conduct text campaigns to members to connect them back to their PCP, and provide in-person education as needed on best practices.
- **Field-based Practice Consultants.** Our Practice Consultants provide hands-on assistance to providers upon request or as identified as needing additional support in adhering to CPGs through our monitoring processes. This is a top need and priority of the MLTC and a successful aspect of CPG incorporation. For example, as part of our OB Quality Incentive Program an OB Practice Consultant will work directly with providers who have gaps in care and opportunities to improve quality performance through the utilization of CPGs. Examples of outcomes across participating affiliates from 2019 to 2020 include a 91% increase in postpartum visits and 22% increase in vaginal births after a cesarean, with a 9% decrease in primary cesarean rates.
- **Quality Team.** The team assists providers to interpret quality data, educates them on CPG expectations, and reviews medical record keeping, confirming accurate evidence of compliance. We also educate and monitor providers on the use of standardized measures shown to improve overall care and services members receive, seen in Figure V.N.79-1.

Figure V.N.79-1. Provider Monitoring.

Provider Monitoring

Source	Description
Care Gap Reports	We distribute reports monthly to PCPs that alert providers about members due or overdue for preventive services, including well-child visits. We also have a dedicated QM Practice Consultant who works with providers with gaps in diabetes services.
Medical Records Reviews	Medical Records Reviews are completed by our QM team through routine audits. The QM team audits provider adherence to CPGs, NCQA and HEDIS® criteria, and Medical Record Reviews. If the provider is not meeting thresholds, our QM team reviews the results with the provider, provides education on the measure, and reviews documentation.
Data Analytics	Through our data mining, we identify provider compliance with HEDIS® measures and CPGs. We provide education tailored to any deficiencies we find during the review. Our HEDIS® reviews with providers include identifying care opportunities and providing feedback on trends. For example, for concerns regarding HEDIS® pediatric visits, we reference our EPSDT CPGs. Upon identification of deficiency, we reach out to the provider to discuss the CPG, what is necessary to meet the clinical standard, and give feedback, such as examples that did not meet the standard. We also provide documentation tools, documentation requirements, and required billing codes to assure compliance.
EBP Incentive Program	Providers will receive incentive payments for incorporating EBP interventions into the delivery of BH services to members. Providers will receive this enhanced reimbursement by including an appropriate EBP tracking code along with a relevant CPT®/HCPCS code in their claims' submissions. Examples of eligible EBP combinations may include the incorporation of Parent-Child Interaction Therapy or Trauma-Focused Cognitive Behavioral Therapy into psychotherapy sessions.

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No. 80

Initiatives for Limiting Waste in the Existing System and Improving Cost Efficiency

For five years, Healthy Blue has implemented programs and initiatives focused on limiting waste and improving cost efficiency in our Nebraska Heritage Health program and the existing system. We define waste as intentional or unintentional over-, under-, or mis-utilization of services, which can include the delivery of unnecessary services, medical mistakes, inappropriate practice patterns, preventable adverse events, duplication of services, complex administrative processes, and fraud and abuse, which result in preventable costs to the program and State. ***Serving more than 113,000 members in Nebraska, we prioritize the delivery of quality care while preventing, detecting, and addressing waste.*** While our Nebraska-specific efforts have resulted in positive outcomes, we recognize the impact of COVID-19 on member utilization and will continue to develop and/or use programs designed to address potential and actual waste. Our strong infrastructure successfully manages waste and improves cost efficiency prior to, during, and following Healthy Blue's acquisition of Wellcare through the following:

- Local experienced and dedicated staff, including Care Management, Utilization Management (UM), Program Integrity, Compliance, Quality Management (QM), Provider Solutions, and Special Investigations Unit (SIU) staff
- Established processes, policies, and procedures for prior authorization reviews and determinations; member education, outreach and engagement; care management, discharge planning, provider education, and referrals to our SIU to identify and address Fraud, Waste, and Abuse (FWA), as appropriate
- Ongoing review and analysis of data (predictive modeling, encounters, claims, prospective and retrospective utilization)
- Comprehensive and ongoing training of, interaction with, and monitoring of our network providers
- Multi-disciplinary Quality Assessment and Performance Improvement Committee (QAPIC) with local experience and knowledge

Our efforts in Nebraska are further supported by the depth of experience from our parent company and affiliate health plans, which serve more than 10.9 million members across 26 markets, that includes Nebraska. In addition to our local expertise, we have leveraged proven cost-saving strategies from our parent company and other markets, while tailoring them specifically to the needs of Nebraskans.

Implementing Specific Initiatives to Improve Cost Containment and Enhance Quality

Healthy Blue takes pride in being a collaborative partner with the Division of MLTC and a good steward of Medicaid funds in Nebraska. As a result, we have developed current and future initiatives to continue our progress in meeting the needs of members through holistic, medically necessary, and cost-effective services, supports, and resources tailored to each member's individualized needs.

Reducing Potentially Preventable Utilization of High-cost Services

As part of our efforts to mitigate and reduce potentially preventable health care utilization, we make sure members and families are aware of all their options and understand and can access the most appropriate services through education and outreach, as also described previously in this section. These alternatives are all intended to augment primary care and preventive services as described in Table V.N.80-1, we recognize the opportunity to impact waste by addressing potentially preventable care, such as preventable inpatient admissions, ED visits, and readmissions.

Table V.N.80-1. Effective Initiatives for Reducing Unnecessary Utilization of High-cost Services.

Reduction in High-cost Utilization – Avoiding Potentially Preventable Care	
Inpatient Cost Containment Program	
Description	Our sophisticated predictive model identifies inpatient cost outliers early, allowing us to address potential barriers and improve member outcomes. Inpatient outlier costs can be predicted on the first day of admission for 30% of the cases, largely comprised of premature babies, transplants, and trauma cases. At least 70% of outlier costs are driven by the member's health deterioration during the hospital stay, such as the need for extracorporeal membrane oxygenation (ECMO), tracheotomies, heart assist, or the intensive care unit. Our model recognizes up to 20 distinct clinical care patterns, leveraging information from preauthorization and inpatient professional claims submitted before the discharge — providing real-time information and insights regarding specialty care or other member needs.
Stakeholders	Health Plan Medical Directors, UM Clinicians, and Care Management team, as well as network providers
Timelines	2021 and ongoing
Desired Outcomes	Expected improvements include: 1) increase in safe and successful transitions; 2) decrease in lengths of stay; and 3) reduced level of medically necessary care.
Emergency Department Avoidance Program	
Description	Unnecessary ED visits can often lead to preventable hospitalizations. This program makes sure members who frequently use the ED receive outreach and education on their benefits and health care options available as alternatives to the ED. We use predictive modeling around avoidable and unavoidable ED visits to optimize the interventions we use, which may include outreach digitally (via text or website) as well as by phone to engage members and support them in accessing the services they need. Using our low-intensity ED predictive model, we identify members likely to have an avoidable ED visit in the next 90 days. This tool is a proactive approach that may be used to reduce ED use for avoidable reasons by identifying members most at risk for having an ED visit within three months. ***Our low-intensity ED model, typically targeting the top 10% of members with high ED***

	utilization, identifies four times more events than random selection. The top decile of the model captures almost half of all Low Intensity ED visits.
Stakeholders	Members, PCPs, specialists, Healthy Blue Care Managers, Community Health Workers (CHWs)
Timelines	2021 and ongoing
Desired Outcomes	Expected improvements include: 1) reduction in ED use among members with high utilization; 2) increase in PCP and other provider engagement; and 3) increase in use of community-based services and resources. [redacted]
Discharge Management Program	
Description	Through this program, we deliver intensive short-term support to transition members from inpatient to outpatient care, helping reduce the risk of an ED visit or readmission after a hospitalization or transition from a facility to the community. We base our program on the Coleman Care Transitions Interventions® (CTI) model, which focuses on coaching members to empower them to better self-manage their conditions. Upon completion of the program, our staff also help close gaps and make sure the member has access to essential services and in-home supports via weekly calls for the first 30 days. They also collaborate with providers and social service agencies to coordinate access to social determinants of health (SDOH), like housing, food, transportation, medical appointments, and other services. [redacted] (Data from 2019 to 2020 utable solely to post discharge interventions.)
Stakeholders	Members, PCPs, specialists, community-based organizations (CBO), Healthy Blue Care Managers
Timelines	Upon notification of the member's admission and 30 days following discharge
Desired Outcomes	Expected improvements include: 1) increase in safe and successful transitions; 2) increase in member engagement in needed services; and 3) reduction in hospital readmissions.
Outpatient Psychotherapy Utilization Audit	
Description	In 2019, we audited BH outpatient psychotherapy providers demonstrating overutilization in places of service of homes, schools, and nursing facilities. In 2020, we expanded this to include audits of outpatient BH providers with high utilization. These audits resulted in additional clinical training and billing training, corrective action, and SIU investigations, as appropriate.
Stakeholders	BH providers, Provider Services, CM team, Medical Directors, and SIU team
Timelines	2019 to Present
Desired Outcomes	Expected improvements include 1) improved provider communication and education, 2) increase in adherence to medical necessity and documentation guidelines, and 3) reduction in BH mis-utilization.
Telehealth Kits	
Description	We provide customized Telehealth Kits, which include asynchronous peripheral devices that assist members and their providers in managing and remotely monitoring their conditions during telehealth visits. The kits promote continuity of care because they offer providers a line of sight into their member's medical state during telehealth visits and diagnostic results. ***Healthy Blue is distributing 1,340 kits to members, including 300 basic kits for members with comorbid chronic conditions, 200 high-risk pregnancy kits, 300 asthma kits, 270 blood pressure kits, and 270 diabetes kits.*** Examples include the following: ▪ **Diabetes Kits.** For members with diabetes, the kit contains items such as fingertip oxygen sensors, blood pressure monitors, digital scales, thermometers, and HbA1c home test kits, which supports them in obtaining accurate readings for virtual sessions and better manage their health at home. For example: ▪ **Asthma Telehealth Kits.** To increase the effectiveness of telehealth visits for asthma, we provide members with kits containing a digital thermometer, phone holder, peak flow meter, spacer, and oxygen sensor. These tools help the member provide valuable information to their provider when accessing care through telehealth that could impact the decisions made about the management of their asthma. ***We are currently in the planning stage for initiatives that increase early identification of asthma so that members can get the diagnostic evaluations and treatment needs to better harness control of their symptoms, improve their quality of life, and decrease poor outcomes.*** ▪ **High-risk Pregnancy Kits.** We also distribute telehealth kits for members with high-risk pregnancies, which provide medical devices to help PCPs make a better assessment and diagnosis of members during telehealth visits. The high-risk pregnancy specialty kits offer support and supplies for PCPs and members to better manage their condition, including a blood pressure cuff, digital thermometer, phone holder, digital scale, protein urine test kid, and O2 sensor.
Stakeholders	Members, PCPs, specialists, CBOs, Healthy Blue Care Managers
Timelines	Initiated in 2022 and ongoing
Desired Outcomes	Expected improvements include: 1) increase in member engagement with providers; 2) increase in member self-management of symptoms; and 3) reduction in ED visits and hospitalizations.

Pharmacy Drug Utilization Review	
Description	Our Pharmacy Drug Utilization Review (DUR) program, including our Controlled Substance Utilization Monitoring (CSUM) program, provides for the ongoing periodic examination of claims data and other records to identify patterns of potential controlled substance FWA; gross overuse or inappropriate or medically unnecessary care; among prescribers and members or associated with specific drugs or groups of drugs processed through the Pharmacy Benefits Manager (PBM). [redacted] We use DUR results for many purposes, such as education with members and/or prescribers on appropriate prescribing, referral of members to pharmacy lock-in programs, referral to internal investigations for suspected FWA; referral to the PBM for pharmacy audits; and provider newsletters.
Stakeholders	Members, PCPs, other prescribers, pharmacies, Healthy Blue Care Managers
Timelines	2021 and ongoing
Desired Outcomes	Expected improvements include: 1) increase in appropriate provider prescribing practices; 2) increase in member adherence to medications; and 3) reduction in ED use for medication-related purposes.
Digital Strategies and Solutions	
Description	[redacted]
Stakeholders	Members, providers, Healthy Blue Care Managers
Timelines	2021 and ongoing
Desired Outcomes	Expected improvements include: 1) increase in member engagement with providers; 2) increase in member self-management of symptoms; and 3) reduction in ED visits and hospitalizations.

Value-based Purchasing Programs for Improving Quality of Care and Reducing High-cost Service Utilization

Our continuum of value-based purchasing (VBP) programs is a key component of our approach to identify, invest in, and reward high-value care and reduce potentially preventable utilization. Our VBPs incentivize providers for improving quality and health outcomes, while driving clinical accountability and cost efficiency. With our support, providers manage the cost of service delivery by reducing unnecessary expenses (such as non-emergent ED use) and focusing on care management for members most at risk for high utilization, effectively coordinating needed specialty care and other techniques. As described in Table V.N.80-2, our VBP programs incentivize providers to improve member health outcomes, encourage innovation, improve the member care experience, lower health care cost trends, and increase quality and efficiency.

[redacted]

[redacted]

Future Initiatives That Address Waste in Nebraska

As described in Table V.N.80-3, we will continue to identify opportunities to address potential and actual waste through the following types of initiative in Nebraska.

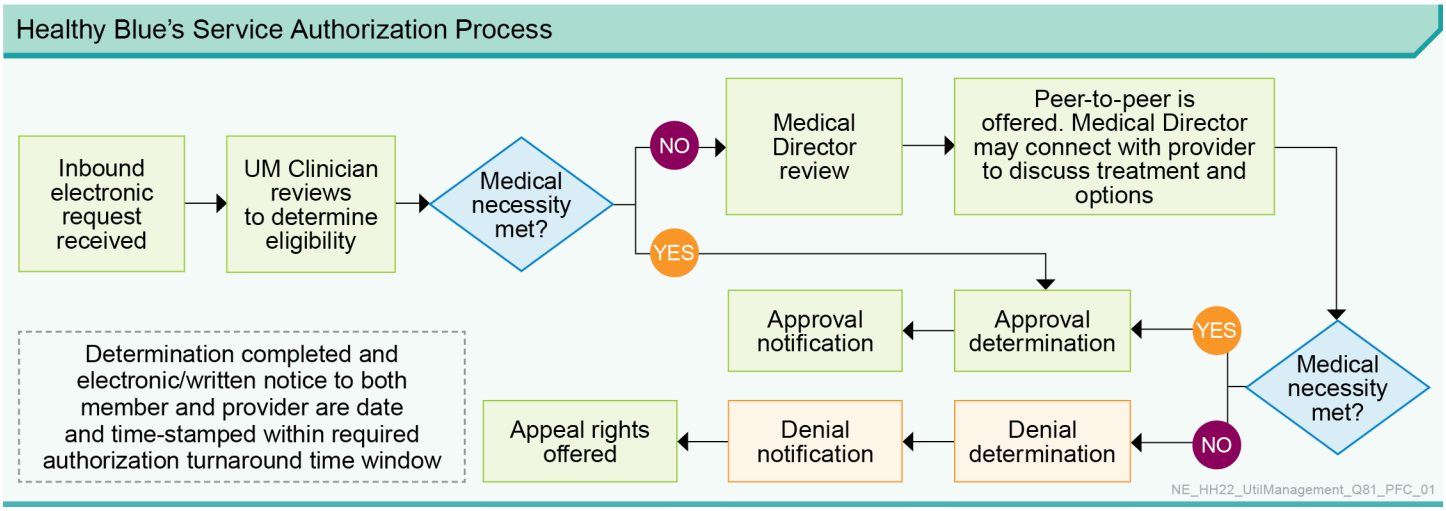
[redacted]

No. 81

Notifying Providers and Members of Service Authorizations and Denials

Healthy Blue does not arbitrarily deny a required service; nor does it deny a service request solely because of the member's diagnosis, type of illness, or condition. We notify the requesting provider and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice meets the requirements of 42 CFR 438.404. We assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a practitioner with the necessary credentials and experience and who has appropriate clinical expertise in treating the member's condition or disease. We follow all NCQA-required standards for denials or decisions and adverse sanctions. We perform ongoing audits of this work and present findings and monitor turnaround times and requirements through our UM and QAPI committees as shown in Figure V.N.81-1.

Figure V.N.81-1. Describing the Flow of Our Service Authorization Process.



Notifying Providers

We communicate with providers through multiple modalities, including verbally via telephonic contact or in-person, and in written format through our secure provider portal messaging system and in Availity. We send denial notices resulting from medical necessity review to members and their treating practitioners and providers (according to policy, federal, and State requirements). A voicemail is not an acceptable form of oral notification; however, we may send a fax as the initial notification. For urgent concurrent denials, our faxes include a statement asking the hospital utilization review department staff to notify the attending/treating practitioner of the decision. For urgent pre-service and urgent concurrent denial decisions, if oral notification was initially provided, electronic or written notification is provided no later than three calendar days after oral notification. For Medicaid decisions, providing verbal notification does not extend the electronic or written notification timeframe. For any adverse determination or partial adverse determination, we promptly notify the provider verbally and in writing.

Pharmacy Prior Authorizations. We review and communicate pharmacy prior authorization outcome decision immediately after the decision is rendered, within 24 hours of the request, by telephone or other telecommunication device. When the prior authorization request satisfies criteria, we approve the request, fax the approval letter to the prescriber and pharmacy, and mail the approval letter to the member. When we approve a prior authorization request, the authorization override with a specified timeframe is automatically loaded into the claims adjudications system in real time, and we pay the claim when processing is complete. If the prior authorization was submitted electronically and all criteria are met, the provider receives an auto-approval. When criteria are not met, we send a fax to the provider and pharmacy indicating that the prior authorization request has been denied and send both the member and provider a letter explaining the specific reason for the denial. The denial letter outlines the appeals procedure, the State Fair Hearing process, and the right to request an independent external review.

Notifying Members

We deliver timely written notification of service authorization decisions, including denials or decisions to authorize services in amount duration or scope that is less than requested, through multiple methods including USPS mail and in our Sydney portal. In circumstances where medical necessity is in question or when we request clinical information to make a decision but has not been received, the clinical staff refers the case within the appropriate timeframes to the appropriate Medical Director for medical necessity review and determination. Physician consultants from appropriate medical, surgical, and BH specialties are accessible and available for consultation. If we make an adverse determination, we communicate the decision according to the timeframes in Table V.N.81-1.

Table V.N.81-1. Standard Timeframe for Completion of Authorization or Payment of Health Care Services Requests.

Type of Request	Decision and Electronic/Written Notification Standard Timeframe
Pre-service (Prospective)	As expeditiously as the member's health condition requires, but no later than 72 hours (three calendar days) from receipt of request
Post-service/Retrospective	Within 30 calendar days from receipt of request
Urgent (Expedited) and Concurrent	As expeditiously as the member's health condition requires, but no later than 72 hours (three calendar days) from receipt of request
Non-urgent	Within 14 calendar days from receipt of request

There are certain circumstances under which we can extend the standard timeframes listed in Table V.N.81-1. For non-urgent pre-service and post-service decisions, if Healthy Blue is unable to decide due to the lack of necessary clinical information, we may extend the decision timeframe. We notify the member or the member's authorized representative of the need for an extension and the date by which a decision is to be made. For urgent care decisions, health care practitioners with knowledge of the member's medical condition (for example, a treating practitioner) act as the member's authorized representative. Members or their authorized representative may agree to extend the decision-making timeframe for urgent, pre-service, and post-service requests. If we extend the timeframes for making standard or expedited authorization decisions, we provide notice to the member of the reason for the delay and informs the member of the right to file a grievance if they disagree with the decision to extend the timeframe. Healthy Blue may deny the request if it does not receive the information within the timeframe, and the member may appeal the denial.

Member Notification of Denial and the Right to Appeal

We send denial notices resulting from medical necessity review to members. Each denial notice is written in member-accessible language and outlines the reasons a requested service is not medically necessary, factors considered, and additional actions available, including the ability to submit an appeal. We provide notice 10 days prior to denials or decisions to authorize services in amount duration or scope that is less than requested. Our member denial letters are compliant with DHHS and are no higher than a 6.9 grade level. If the denial is due to lack of clinical information and there is insufficient clinical information to reference a specific guideline or criterion (for a given condition, service request), the notification states the inability to reference the specific criteria, and describes the information needed to render a decision, in easily understandable language including:

- Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criteria on which the denial decision was based, upon request
- A description of appeal rights — the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeal process, including:
  - A statement that members may be represented by anyone they choose, including an attorney
  - The availability of an applicable office of health insurance consumer assistance or ombudsman
  - The timeframe for the member to file an appeal and for Healthy Blue to make a decision
  - The procedure for filing an appeal, including where to direct the appeal and information to include in the appeal
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials

Timely Adverse Determinations and Appeals Notification to Members

Peer-to-peer conversations give practitioners the opportunity to discuss impending or issued medical necessity adverse determinations with a peer clinical reviewer. Peer clinical reviewers are available to discuss determinations with attending/treating practitioners. Practitioners receive notification about the availability of, and how to contact, a Medical Director (or appropriate practitioner reviewer) to discuss medical necessity denial decisions; in most instances, this is recorded as verbal denial notification. The following information is included in the denial recorded within the member's EHR:

- The denial notification if the treating practitioner was notified in the denial notification
- The time and date of the denial notification and the name of the individual, if the treating practitioner was notified by telephone
- Evidence the treating practitioner was notified that a physician or other reviewer is available to discuss the denial

Members and treating providers may request a second medical opinion or appeal an adverse decision. We provide information about these processes in both the member and provider handbooks and in the adverse decision communication that is sent to both the member and the provider. Following an initial denial, there are several remedies available to providers, including reconsideration, peer-to-peer discussion, and an appeal. Medical Directors can reverse an adverse determination upon receipt of previously missing clinical information. When an appeal is requested, it is performed by an independent physician of the same or similar specialty as the original requestor and a physician not familiar with the initial reviewer. Our UM staff, along with our Provider Experience Representatives, reinforce information about the appeals process in their interactions with members and providers. If the UM Clinician is unable to ascertain sufficient information to determine medical necessity, the request is routed to a licensed Medical Director, who makes consistent medical necessity decisions in accordance with State and NCQA standards. The Medical Director discusses service options with the treating provider and consults with a qualified external physician reviewer specializing in the services requested, as indicated, prior to making a decision.

Monitoring and Ensuring Notification Timeliness

Healthy Blue deploys two primary mechanisms to ensure compliance with UM policies and procedures and the consistent application of review criteria — Inter-Rater Reliability Audits (IRR) and our Performance Improvement and Enhancement (PIE) program. Our auditing processes identify the effectiveness of our UM Clinicians, physicians, and processes for medical necessity determinations by identifying over- and under-utilization, provider profiling, and quality of care issues. A Medical Director participates in a monthly UM IRR review forum with all psychiatric reviewers and submits a minimum of two cases per year for the assessments.

- **IRR Audits.** Our audit program uses hypothetical UM test cases or a sample of UM determination files along with an NCQA-approved auditing method to evaluate the consistent application of criteria. Medical Directors and UM Clinicians who do not meet the targeted standard are subject to a corrective action plan to bring their performance up to plan expectations. None of our Medical Directors have ever been under corrective action.
- **PIE Program.** Our PIE program supports consistent application of review criteria for authorization decisions and continuously evaluates our UM program using monthly clinical (including physicians) and non-clinical staff audits (including call reviews), outcomes reporting, and process validation for compliance with UM policies.

We report individual performance and overall UM department IRR and PIE results to our Chief Medical Officer, Medical Management Coordinator, Clinical Services Committee, and QAPI committee annually as required.

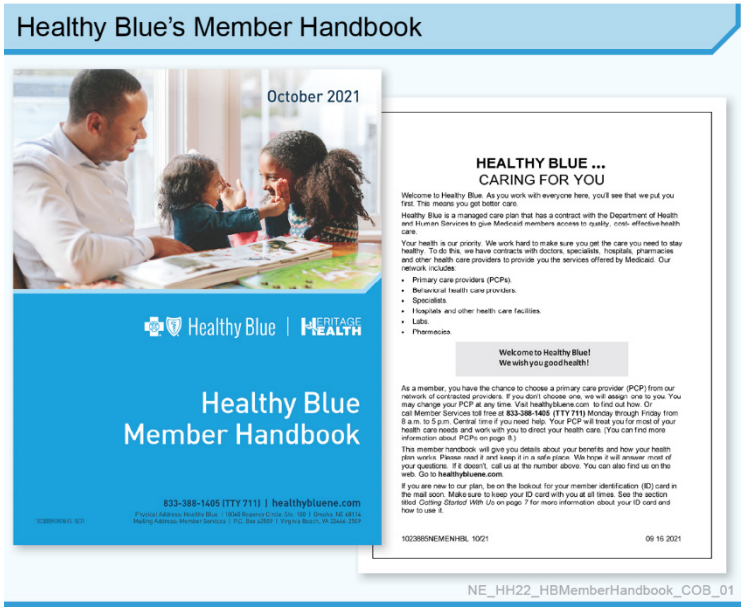
No. 82

Describing the Services Requiring Prior Authorization

We will comply with the requirements detailed in SOW N.4. We do not require prior authorization for emergency services. Healthy Blue and our subcontractors have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. The following services are subject to prior authorization and we include a complete list in Attachment V.N.82-1:

- Elective or planned inpatient admissions
- Specialty procedures (the organization does not require pre-certification for specialty care emergency services for treatment of any immediately life-threatening medical condition)
- Non-emergent services rendered by an out-of-network practitioner or provider, with the exception of covered EPSDT services, covered family planning services and women's preventive health services, unless excluded by DHHS or federal requirements
- Home Health
- Certain durable medical equipment
- Certain medications (described in pharmacy program description)
- Certain diagnostic procedures

Figure V.N.82-1. Communicating Prior Authorization Requirements in Our Member Handbook.



Communicating Prior Authorization Requirements to Members

We communicate with members in meaningful ways, including traditional mail, in-person, by telephone, and digitally on our member website and through Sydney Health (mobile and online) app. We provide information to members on the services that require authorization and ways in which they can request those services at any time through our member handbook and member website. We provide members with information about prior authorization requirement in our quick start guide and member handbook as shown in Figure V.N.82-1. To assure responsiveness to member requests for services through our Member Services Call Center, our Member Services team receives training on services that require prior authorization and ways in which members can request those services at any time. Member Services Representatives who receive service requests through the Member Services Call Center route member requests to the UM department for processing and documents the call information in our Core Service Platform (CSP).

Communicating Prior Authorization Requirements to Providers

Provider Promise

Healthy Blue's continued collaboration and partnership with Nebraska providers is a foundational element of our strategy to assure equitable, whole-person care to members and improve population health. We believe provider education and training is essential to the success of any member experience endeavor and is particularly important when providers join the Medicaid program. This is part of our Provider Promise to achieve health communities through our resolute commitment to simplify health care so that providers can focus on health. Our provider training plan forms the foundation for our long-term, collaborative provider relationships, and our programs reflect lessons learned and best practices. In our provider handbook and available on our website, we include our Healthy Blue coverage requirements for Medicaid and Long-Term Services and Supports, our EPSDT toolkit, prior authorization requirements, preventive health screenings, and EPSDT special services. We also provide online medical policies and clinical UM guidelines, a provider quick reference guide, online Centers of Medical Excellence Transplant Operations Manual, and training on AIM services.

Our UM Clinicians work directly with providers to discuss the prior authorization process. This regular interaction provides the opportunity to gather valuable provider feedback that can be integrated into future provider training opportunities and incorporate their feedback into our process to help reduce administrative effort and improve overall provider experience. [redacted] orking collaboratively with providers and provider technology solution companies, we have developed effective administrative processes and data sharing that support health care delivery improvements, in the following areas: avoidance of duplication of services, patient safety, prevention and wellness, chronic Disease Management, and member satisfaction. Establishing interoperability through seamless and secure exchange of digital information gives Healthy Blue and our network providers access to data that facilitates better workflow and improves collaboration. We offer providers multiple tools to communicate prior authorization requirements and to simplify the process including:

- **Pre-certification Look-up Tool (PLUTO).** This tool supports providers in identifying services that require prior authorization. Providers can select the service from a drop-down box, view which clinical practice guidelines are related to requested codes, directions for completing the request, and information on how to reach Anthem for assistance.

- **Our Provider Website.** This website includes a publicly accessible side and a HIPAA/HITECH-secure provider portal deployed through Availity. Availity is a robust, multi-payer portal that offers online functionality such as claim submission and inquiry, claim dispute submission and tracking, and prior authorization submission.
- **Core Service Platform.** We record all requests for prior authorization in our CSP, which is electronically signed by a UM Clinician and includes their credentials and qualifications, along with their appropriate suffix.

In addition to these tools, when codes are removed from PA, communication of codes removed from PA may be published on the provider website and or by email or fax blast.

Providing Prior Authorization Training and Support to Providers. We engage providers early and often and provide additional training and resources to office staff to reduce administrative burden and to simplify the prior authorization process. We go beyond basic health plan training with providers and collaborate to enhance access and improve quality through telehealth programming, open panel, and extended office hours incentives. We call our approach to provider collaboration our Provider Pledge because we know that the best way to achieve healthy communities is through our resolute commitment to simplifying health care so providers can focus on delivering care. Our local Provider Experience team aligns the various activities that support providers into a seamless experience to minimize administrative burden. Healthy Blue's field-based staff collaborate directly with providers in the very communities in which they live. Because we identified a particular need for claims education and support, we also have a dedicated Nebraska Provider Claims Educator position. Our commitment to training is reflected in our Medicaid Training Academy. In line with our Provider Promise to simplify health care so providers can focus on their patients, Healthy Blue offers educational and training resources through the Academy that empower our providers to provide high quality, culturally sensitive, and cost- effective care.The Academy reflects our commitment to delivering the right curriculum, at the right time, to empower providers to succeed. It serves as a hub for provider information, technical assistance, training, and curricula that begins with new provider orientation and continues with ongoing education opportunities and resources to reinforce learning. Providers can access the Academy 24/7/365 via both our provider website and our secure provider portal (Availity). Our Care Delivery Transformation (CDT) team offers support to providers using multiple modalities including:

- **New Provider Orientation.** In-person, virtual, and recorded versions of sessions completed within 30 days of placing a newly contracted provider on active status
- **Provider Pathways.** Self-paced digital platform which educates providers on working with Healthy Blue and includes refresher courses on multiple topics
- **Individual Training.** Ad hoc training available to all Healthy Blue providers
- **Group Training.** Targeted training upon significant changes to Healthy Blue program requirements or process changes; settings include town halls, lunch and learns, provider forums and workshops, and association meetings (settings were adjusted to virtual during the ongoing public health emergency)
- **On-demand/Online Resources.** Online resources include toolkits (for example the cultural competence or CMS telehealth toolkits), the provider handbook, provider newsletter, and online bulletins and e-updates
- **Additional Provider Services and Outreach.** Ongoing communications through newsletters, emails, and fax blasts

To identify specific provider training, education, and outreach needs, we engage and collaborate with DHHS as well as providers, provider associations, and other stakeholders. We also monitor trends, such as claim denials, by individual providers and provider groups and provide one-on-one or group trainings for providers experiencing persistent issues. We provide examples of training and resource materials available to our providers through the Academy in Table V.N.82-1.

Table V.N.82-1. Healthy Blue Offers a Variety of Provider Resources and Training Topics.

Manuals and Resources	Training Academy Modules	Additional Trainings Available
Nebraska Provider Handbook	Healthy Blue Provider Orientation	Behavioral Health for PCPs
Provider Quick Reference Guide	Behavioral Health Provider Orientation	Pharmacy Formulary
Centers of Medical Excellence Transplant Operations Manual	Electronic Funds Transfer	Principles of Rehabilitation and Recovery from Mental Illness and Substance Use Disorder
Healthy Blue FAQs	Interactive Care Reviewer	Trauma-informed Care
Healthy Blue Policies and Procedures	Clinical Practice Standards and Utilization Management Programs	Identification of Special Needs Members
Nebraska Health Link Requirements	Telehealth Toolkit for Providers	Appropriate Use of Emergency Department Services
Healthy Blue Medicaid Coverage Requirements for EPSDT, Prior Authorization, and Preventive Health Screenings		Care Management, Discharge Planning, Prevention, and Disease and Population Health Management

No. 83

Conducting Concurrent Reviews for Inpatient Services

Concurrent reviews facilitate smooth transitions to and from higher levels of care (including hospital, rehab, and skilled nursing) and monitors for potential overuse of inpatient services. Upon notification of admission, Healthy Blue Utilization Management (UM) Clinicians work with facility staff to monitor member progress and discharge planning efforts. Each member's case is individualized by the presenting symptoms and intensity of services needed, and we work closely with hospital staff, the member, family, and the discharge planning team to safely transition the member to a lower level of care (LOC), make sure all care needs are identified, and confirm appropriate services are in place. Our process for concurrent review for inpatient services monitors medical necessity during the member's stay. Procedures include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on medical necessity. Our concurrent review process assures members receive a high standard of evidence-based appropriate care that promotes quality by:

- Defining the on-site and telephonic review protocol process
- Assessing members' progress and needs during an inpatient stay
- Coordinating members' needs prior to discharge
- Facilitating members' transitions from inpatient through discharge
- Avoiding delays in discharge due to unanticipated care needs

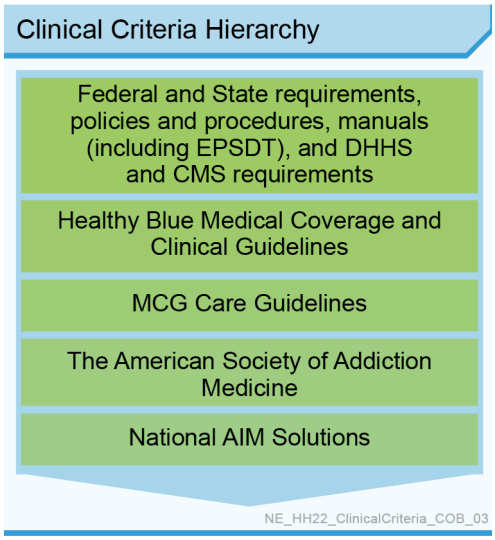
Our care guidelines include nationally recognized, evidence-based clinical guidelines that support care coordination across the continuum of care, such as inpatient and outpatient reviews, concurrent reviews, and rehabilitation. We use approved clinical practice guidelines (CPGs) uniformly for all populations, in particular ***acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility, and BH inpatient***. Medical Coverage and CPGs are internally developed guidelines based on national Medicaid guidelines and best practices, local practices, and clinical tools for inpatient, outpatient, and BH reviews. Our licensed physical and BH UM clinicians (licensed mental health counselors, licensed clinical addiction counselors, licensed clinical social workers, and registered nurses) use the results from tools completed by physical health and BH providers to support clinical decision-making. This includes tools such as Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS) Scale, and Child and Adolescent Service Intensity Instrument (CASII).

Using Evidence-based Physical and Behavioral Health Guidelines During Concurrent Reviews

As a part of our clinical criteria hierarchy, we rank State and federal guidelines, nationally recognized and evidence-based criteria, best practices, and other decision-making tools to inform our decision-making processes as shown in Figure V.N.83-1 and include:

- ***DHHS and CMS*** requirements.
- ***MCG® Care Guidelines***, including nationally recognized, evidence-based clinical guidelines that support care coordination across the continuum of care, including inpatient concurrent reviews. We will use approved MCG Care Guidelines uniformly for all populations, in particular acute inpatient, skilled nursing facility, acute inpatient rehabilitation, long-term acute care facility, and BH inpatient. When population-specific recommendations are warranted, those are detailed in the clinical indications and are often accompanied by highly informative descriptions of evidentiary support in the Evidence Summary.
- ***Healthy Blue medical coverage and clinical guidelines*** are internally developed guidelines based on national Medicaid guidelines and best practices, local practices, and clinical tools for inpatient, outpatient, and BH reviews. Our licensed BH Clinicians (licensed mental health counselors, licensed clinical addiction counselors, licensed clinical social workers) use the results from tools completed by physical health and BH providers.
- ***The American Society of Addiction Medicine*** provides nationally recognized, evidence-based BH clinical guidelines for the treatment of SUD, including opioid use disorder.
- ***National AIM Solutions*** include tools designed to help providers request the most appropriate treatments and tests for members with complex clinical needs, including rehabilitation, musculoskeletal care, sleep therapy, radiology, radiation therapy, genetics, and cardiology. We assure AIM Solutions' clinical criteria align with Healthy Blue's CPGs and adhere to our processes for changes and updates (including health plan approval, State approval, and provider notifications).

Figure V.N.83-1. Clinical Guidelines Inform Our Concurrent Reviews.



Healthy Blue's comprehensive UM policies and procedures, systems, use of MCG Care Guidelines and experienced staff help assure accurate and consistent application of clinical review criteria for initial and continuing service authorization. Our policies and procedures guide initial, concurrent, and post service reviews in accordance with our contract with the State. Our application of CPGs is based on the individual needs of members. Our UM program policies and procedures meet all contract, State, and federal requirements and are developed with Healthy Blue providers through Nebraska Clinical Services and Medical Advisory Committees. We require our subcontractors to maintain consistent policies and procedures that help guide requests for initial or continued authorization of services.

Healthy Blue's Concurrent Review Process

Our concurrent review process uses CPGs that are subjected to rigorous initial and ongoing processes that assure they are and continue to be current, best practice, and locally pertinent. Our concurrent review system includes provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on the medical necessity determination. An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical

guidelines. Healthy Blue uses published and commercially available criteria for hospital case reviews to facilitate evaluation by utilization review nurses.

If a stay does not meet standard criteria, the appropriate Medical Director reviews the case and a determination is made based on the member's individual circumstances. Upon notification of an admission, our Concurrent Review Clinician attempts to obtain clinical information to review. Clinicians make decisions in accordance with currently accepted medical or health care practices, considering special circumstances requiring deviation from the norm. Our Concurrent Review Clinician performs the following activities:

- Approves admissions and continuing lengths of stay using the nationally recognized MCG Care Guidelines criteria, BH medical necessity criteria, or ASAM criteria
- Obtains clinical information to substantiate continued inpatient care upon notification of the admission
- Contacts the attending physician directly or has the appropriate Medical Director establish contact if the needed clinical information cannot be obtained through the on-site clinical review process or from the hospital UM peer reviewer
- Provides continued length-of-stay authorization at each concurrent review interval, if case meets continued acute inpatient stay criteria
- Notifies the attending physician and/or hospital UM Specialist for additional information if the admission or continued inpatient stay does not meet medical necessity criteria
- Contacts the attending physician and/or hospital UM Specialist if the member's LOC placement does not meet the appropriate medical necessity criteria
- Contacts the appropriate Medical Director within the appropriate timeframes for medical necessity review and determination if the medical necessity criteria or LOC placement is not met, or when clinical information needed to make a decision has been requested but not received
- Notifies the provider of the decision as policy requires
- Performs discharge planning activities, including the coordination of care needs for psychosocial, economic, and other variables related to discharge planning
- Refers members with complex cases and ongoing needs for case management or BH programs per plan guidelines
- Confirms required notices are sent to treating practitioners and members, and facilities if applicable, within required timeframes
- Upon discharge of the member, verifies the documentation is completed in the authorization database following our documentation guidelines
- For BH discharges, makes certain the member has a follow-up appointment within seven days of discharge and documents the location, time, and practitioner in the discharge notes
- Refers to our Quality Management/Quality Improvement department if at any time the Concurrent Review Clinician identifies a potential quality issue through the review process

For BH services, we review requests for services for authorization, reauthorization, or in some cases only require notification that the service is being provided. Our process, concurrent review for ongoing care, bases the service decision on ongoing individual needs, medical necessity, and standard guidelines. UM staff are assigned by facility for familiarity with the treatment provided and demographic needs of the area and available services.

Assuring Timeliness of Our Concurrent Review Process. UM performance monitoring is a formalized function within Healthy Blue that helps ensure timeliness of our concurrent review process. Monitoring UM activities helps us identify opportunities for improvement that can lead to delivery of higher quality services, more efficient operations, and improved member and provider satisfaction. Our auditing processes identify the effectiveness of our UM Clinicians, physicians, and processes for medical necessity determinations. We assure UM clinical staff concurrent review timeliness, compliance with UM policies and procedures, adherence to our adopted criteria, and consistency and appropriateness of medical necessity determinations through our Inter-Rater Reliability (IRR) and Performance Improvement and Enhancement (PIE) programs. These audits are independently and objectively conducted by the Enterprise Clinical Support team. We conduct NCQA-approved annual IRR audits of all Medical Directors and UM Clinicians to evaluate consistency and accuracy in applying UM criteria, and to help us assure we are treating members and providers fairly and consistently when delivering covered benefits and services.

Concurrent Reviews for Hospitals, Rehab, and Skilled Nursing

We conduct concurrent review for inpatient and residential services and continued stay review for nursing facility services when the provider and member determine treatment should continue beyond initial authorization and make decisions within one calendar day. In coordination with the provider, the UM Reviewer engages care management and discharge planning for placement, medications, and authorizations as needed. In performing concurrent and continued stay reviews, UM Reviewers assess individual member progress and needs during the episode of care and coordinate before discharge to facilitate the member's smooth transition between levels of care or to home, and to prevent delays in discharge caused by unanticipated care needs. Healthy Blue will not deny continuation of higher-level services, such as inpatient hospital, for failure to meet medical necessity criteria unless we can provide the service through a provider at a lower LOC. We support members through our concurrent review process in facilities including:

- **Hospital.** To complete concurrent reviews when members admit to the hospital, we review and monitor the case and determine the member's individual needs, severity of illness and services rendered to extend the hospital stay or other services as needed.
- **Rehab.** When completing concurrent reviews for members who admit to rehab, they all are reviewed by our Medical Director.
- **Skilled Nursing.** When a member admits to skilled nursing, we work with the facility staff to assure all PASRR requirements are met, and that the facility can meet the needs of members with behavioral health conditions.

We conduct on-site reviews for physical health services with designated clinical staff who review charts at the facility where the member has been admitted. These reviews are preferred because specific clinical information as it relates to the admission is obtained succinctly. Our hands-on approach allows for an improved quality of clinical review, which is useful information for discharge planning, rounding activities and assessing members for case management services.

No. 84

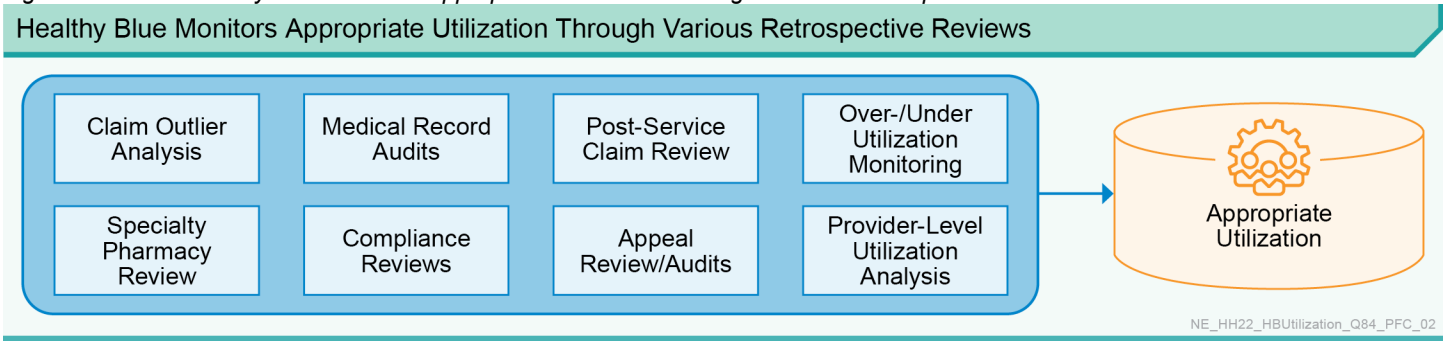
Healthy Blue Conducts Retrospective Reviews to Examine Trends in Utilization

Healthy Blue's utilization management (UM) program conducts retrospective utilization reviews to examine favorable and unfavorable trends and issues. This is part of the overall UM program mission to assure we deliver the right care, at the right time, at the right place.

Healthy Blue's Quality Assessment and Performance Improvement (QAPI) program evaluates under- and over-utilization of services through a multi-faceted approach. We identify under-utilization in preventive and disease-specific services through the monthly data runs of HEDIS® metrics compared with national, regional, and internal benchmarks. We are vigilant about measures associated with preventive services, for both adults and children, to assure there is not under-utilization. For example, between 2018 and 2021, our Cervical Cancer Screening went from the 25th to the 90th percentile, and our child immunizations (Combo 10) improved from the 66th percentile to the 90th percentile. [redacted]

We assure against over-utilization by retrospective reviews that identify deviations against established outlier criteria, as shown in Figure V.N.84-1. These reviews can trigger audits and investigations by our Compliance team and our Special Investigation Unit (SIU). These reviews are grounded in our commitment to assuring medical necessity is established at the individual level, overriding, where appropriate, prior authorization (PA) requests that do not meet criteria.

Figure V.N.84-1. Healthy Blue Monitors Appropriate Utilization Through Various Retrospective Reviews.



Our process for retrospective review includes the following:

- A system to identify utilization patterns of all network providers by data elements such service types, geography, place of service, and established outlier criteria for both inpatient and outpatient services
- Written policies and procedures through which the prescriber of pharmacy services can submit additional information for special consideration and additional review of denied PA requests that do not meet criteria
- Retrospective and peer reviews of a sample of network providers to ensure that services furnished by network providers were provided to members, appropriate and medically necessary, and authorized and billed in accordance with state requirements
- Provider reviews related to Medicaid compliance issues
- Procedures, based on best practices in the industry, which focus resources on individual and system outliers
- Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under- and over-utilization of services at all levels of care, including monitoring members' utilization of services by race, ethnicity, gender, and age
- Retrospective review of processes for claims denials ensure that claims are denied individually (that is, each denied claim must be specifically reviewed) and any denial must be subjected to due process before payment is withheld or repaid
- An appeal process that includes standard communication with reasonable timelines, utilization review criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims

Our approach to conducting retrospective reviews is collaborative and involves frequent and open communication with our providers. Tami DeBonis, RN, Medical Management Coordinator, works with the UM Clinical team daily and the UM Committee quarterly to identify and address trends in under- and over-utilization. Our Utilization Management Committee (UMC) and our UM Clinical team have defined roles and responsibilities outlined next that encompass communication, engagement, and education of providers and members.

Utilization Management Committee

Our UMC is a proactive committee that engages continuously in quality improvement activities. It is responsible for analyzing, reviewing, and making recommendations to plan, implement, and measure the outcomes of clinical improvement studies and program improvement plans. One of its key responsibilities is to monitor over- and under-utilization. The UMC reviews data on at least a quarterly basis including paid claims, and looks for utilization changes over monthly, quarterly, annual, and year-over-year periods. The UMC develops action plans for improvements as needed, which includes addressing over- and under-utilization of health care resources. The UMC is responsible for adopting and implementing changes to the PA requirements, and for reviewing and updating UM and care management quality and program metrics. The UMC evaluates opportunities to increase inter-departmental collaborations across quality and utilization improvement activities.

The UMC identifies under- and over-utilization at the population health level and participates in the population health program through the review and analysis of the following reports:

- HEDIS Data
- Fraud, Waste, and Abuse Notification Report
- Prior Authorization Reports
- Service Utilization (Claims Data)
- Prescribing Patterns and Pharmacy Utilization
- Type of ED Utilization
- Inpatient Readmissions
- Member Grievances and Appeals

Our Health Care Analytics team monitors authorization and claim outliers at the program level and the provider level and refers specific recommendations to the shared service and local clinical teams for follow-up. Working with Provider Services, the clinical teams request records as necessary and discuss the reason for the variance. Depending on the outcome of the analysis and conversation, the results and recommended actions are brought to the UMC for discussion and approval.

Review for over-utilization of services at the population level includes a focus on ED, pharmacy, and Non-Emergency Medical Transportation (NEMT) services. We also identify under-utilization of services that may prevent the inappropriate use of the ED, including BH services, preventive care, and unfilled prescriptions. We review reports to determine trends in aberrant behavior and report over- and under-utilization outliers to the QAPI program for review and development of performance improvement activities. We implement strategies to achieve utilization targets consistent with clinical and quality indicators and to identify fraud and abuse. Our current priorities are reviewing for patterns of over and under-utilization in the following areas: hospital readmissions, pharmaceuticals, specialty referrals, ED utilization, home health and durable medical equipment, BH, inpatient utilization, well-child/adult PCP visits, age-appropriate immunizations, mammograms, blood lead testing, and opioid use.
At our quarterly UMC meetings, our Chief Medical Officer, Case Management Administrator, and Medical Management Coordinator monitor provider quality and utilization trends through provider profiling, member feedback, and quality improvement data analytics.

UM Clinical Team

Healthy Blue's Clinical team reviews multiple data sources on a daily, weekly, and monthly basis. This includes reviews of real or near-real-time data on ED usage, pharmacy claims, and authorization requests. This team reviews for gaps in care, particularly around preventive care measures and unused referrals or prescriptions. Once we identify members or providers with patterns indicating potential over- or under-utilization of services, we initiate outreach and education.

Responding to Member Utilization Trends

Our parent company trends member utilization at a regional level and develops heat maps to pinpoint opportunities for intervention. In mid-2021, heat maps indicated an increasing trend in inpatient utilization in Nebraska driven by short stays. Members with short stays had a preponderance of a type 2 diabetes diagnosis. [redacted]

UM clinicians discuss authorization requests with the UM Manager during daily interactions and UM rounds, and our Medical Directors during clinical care rounds, to assure we connect members with the most appropriate services and care coordination. Our Medical Management Coordinator shares information gathered from our daily processes with the UMC and QAPIC to assist in identifying trends.

Responding to Provider Patterns

The Clinical team conducts regular retrospective reviews of a sample of network providers to make sure services are furnished, medically necessary, authorized, and billed in accordance with State and plan requirements. Aberrant provider practice patterns can have different root causes. For example, there may be appropriate extra services requested when a member is very sick or not improving or may be due to a lack of insight in a provider's practice, whereby the provider does not realize they have practice patterns that fall outside of the norm. Aberrant practices may also be related to a provider's overt abuse of the system. Identifying aberrant patterns is a priority at Healthy Blue. When our UM Clinical team identifies questionable trends, they track them and collaborate with other key personnel, such as our Provider Services Manager, QM Coordinator, Contract Compliance Officer, and SIU Manager to determine next steps.

When we identify providers having significant aberrant patterns of utilization, the Medical Management Coordinator and Provider Experience Representatives review to determine actual utilization of services. The Provider Experience Representative, with support from the Medical Management Coordinator as needed, develops a performance improvement plan; discusses the plan with the provider, and improves outcomes through technical assistance and training. We continue to monitor and trends in the utilization patterns of identified members and providers. Once a six-month period has passed after initiating the performance improvement plan, or earlier as indicated, the Healthy Blue or Regional Medical Director or designee reviews the provider's performance. We employ routine methods for addressing provider continuance of inappropriate utilization. We also identify whether there is a broader educational opportunity for all our providers and address re-training through methods such as e-mail blast or webinars.

Post-Service Clinical Claim Review

Our Post-Service Clinical Claim Review (PSCCR) department provides retrospective medical necessity reviews on submitted claims. A post-service review decision is based on the medical information available to the attending or ordering health care provider at the time the care was provided and our medical policy and clinical guidelines, including AIM and IngenioRx clinical guidelines. The PSCCR team, based in our national Reimbursement Policy Management department, evaluates the medical necessity of claims pended due to potential coding issues. The PSCCR follows claims turnaround times of less than 30 calendar days. The team includes registered nurses and certified professional coders who bring to bear their clinical and coding expertise to uphold optimal decision making.

No. 85

Healthy Blue's Approach to Ensure Provision of Appropriate and Cost-effective Care

Healthy Blue's utilization management (UM) and care management programs promote health care delivery in the most appropriate setting and address inappropriate emergency department (ED) utilization, avoidable hospitalizations, and hospital readmissions. We use a data-driven approach to identify members at risk or with overutilization and to understand contributing factors, so that we can offer focused interventions that engage and connect members to the most appropriate services and supports that meet their needs. Our approach rests on a foundation of provider and member education, analytical tools, including predictive models, and identification of members for engagement in specific care and case management and UM programs. [redacted]

Initiatives to Control Emergency Department Utilization, Avoidable Hospitalizations, and Hospital Readmissions

Table V.N.85-1 briefly summarizes the array of initiatives we employ to target and reduce avoidable ED use and hospital admissions or readmissions. We describe selected initiatives in more detail throughout the remainder of this section.

Table V.N.85-1. Our Member, Provider, and Care Management Programs Support Member Access to the Right Care at the Right Time.

Initiative	Overview
Member Education	We use printed materials, calls, texts, email, the Sydney Health (Sydney) App, and face-to-face contacts (according to member preference) to inform all members on how to access primary care, including the importance of receiving routine care from a PCP, the appropriate use of the ED, and who to contact for care and case management assistance.
24/7 Nurse Helpline and Behavioral Health (BH) Service Line Support	Our 24/7 Nurse Helpline and BH service line are available to help members identify alternatives to ED use, connect members to community crisis services and other supports, and to the Care Management team for additional assistance addressing health care needs.
[redacted]	[redacted]
Provider Education	We educate providers during orientation and ongoing training on our evidence-based clinical practice guidelines; primary care and specialty care provider responsibilities; initiatives targeting ED overuse and avoidable hospital admission and readmission; access to Patient360 to view members' overall care history; and how to refer members for care and case management support to avoid or address overuse.
Network Maximization	We encourage providers to offer extended office hours and continually identify new providers to join our network. We also recruit and contract with providers in contiguous states (for example, Colorado, Kansas, Iowa) to address specialty shortages. For example, we contract with the University of Colorado Medicine for specialty care to ensure our Western Nebraska Members have access.
Telehealth	Our telehealth options provide access to primary and specialty care, including BH care, to promote timely and convenient access to care at home. We also offer videoconferencing options that connect the member with their provider for completion of a health care visit in their home.
Value-based Purchasing (VBP) Programs	We encourage providers to participate in our VBP programs that include incentives for achieving specified quality benchmarks related to access to care and delivery of high-quality preventive, chronic condition, prenatal and postpartum care.
Predictive Modeling	Our suite of predictive modeling tools helps us proactively identify members at-risk of future ED use and hospital admissions/readmission so we can engage members in the appropriate level of care and case management to prevent future, avoidable high-cost service use.
[redacted]	[redacted]

Strategies That Address Access to and Use of Primary Care, Other Clinic Services, Urgent Care, and Retail Clinics

Healthy Blue is committed to maintaining a network that meets the health care needs of its members. From our extensive experience developing high-quality provider networks, we understand the specific health care, geographic, cultural needs, and preferences of Heritage Health members. We offer a robust network of primary care and other clinic services, as well as an array of convenient urgent care and retail clinic options that include telehealth, to provide timely access to necessary services and are fully compliant with primary care access requirements.

Because provider access and availability are critical to avoiding unnecessary ED visits and inpatient admissions/readmissions, we monitor contracted PCPs and specialists quarterly to determine compliance with appointment availability and wait time standards, and we use our findings to intervene with providers to increase their availability. [redacted]

[redacted]

We continually invite new providers to join our network, encourage providers to extend their office hours, and contact providers with closed panels to make sure there are no problems with Healthy Blue that upon resolution would open the panel to our members. We educate and engage providers in promoting appropriate and timely health care for our members and encourage them to participate in our VBP programs that drive improved quality and outcomes.

Initiatives That Increase Access to Timely Care. We identify and implement innovative solutions that are sensitive to member's complex needs, limited resources, and geographic barriers and describe selected initiatives in more detail in Table V.N.85-2. For example, Healthy Blue's telehealth strategy (described in detail in our response to Question 21) helps members better manage their care at home, which is an important part of our approach to avoiding unnecessary ED admissions. [redacted]

[redacted]

Controlling Inappropriate Emergency Department Admissions

Healthy Blue employs targeted initiatives for members with frequent ED use, or at risk of future ED use, which includes our ED Diversion program messaging (described in Table V.N.85-1) and ED Avoidance Program. We focus on identifying and intervening with members to prevent inappropriate ED use. We use available data and employ predictive models to prioritize members for care and case management outreach, care coordination, and education as applicable to the member's needs.

[redacted]

[redacted]

Member Identification and Outreach

Our Care Management team contacts members with three or more avoidable ED visits and those identified as high-risk through predictive modeling, and explores ways to reduce future, potential ED use. We use SMS/text, email, and the Sydney app to increase the likelihood we will reach and engage the member. Once the member is engaged, we assess the reasons for their ED visits, provide member education on appropriate ED use, and address the member's specific needs, which may include:

- Connecting members to transportation
- Helping members schedule an appointment with their PCP or specialist
- Upon request, identifying and connecting the member to other primary care and specialty providers who may be a better match for the member based on their location, primary needs, and preferences
- Discussing health care options available through urgent care providers, retail clinics, and LiveHealth Online (telehealth services)
- Connecting members with complex conditions and situations, including housing instability and interpersonal violence, to a Care Manager (CM) for ongoing, comprehensive care or case management assistance

Our Marketing and Community Relations Representatives who staff our Welcome Rooms offer member education on accessing the right care at the right time at our Welcome Rooms. We discuss the PCP being the preferred choice for non-urgent issues, the importance of completing follow-up visits and wellness checks, and when to use urgent care (for fever, vomiting, sprains, strains, x-rays, small cuts, and back pain, for example).

Behavioral Health Emergency Department Incentive Program

Our Behavioral Health Emergency Department Incentive Program (BHEDIP) incentivizes acute care hospitals with EDs to promote coordination with the ED's PCPs and BH professionals. Program objectives include increasing Medication-Assisted Treatment (MAT) induction rates, promoting holistic care for members (BH and physical health), increasing initiation and engagement of BH treatment in the most appropriate treatment setting, reducing risk of overdose, and improving care coordination between providers involved in a member's BH treatment. [redacted]

Preventing Hospitalizations

All members, including those with ambulatory care-sensitive conditions and complex needs, require access to the right care at the right time and place to avoid unnecessary hospital admissions and readmissions. We identify members at greatest risk for future hospitalization for engagement in our complex case management programs through:

- [redacted]
- From the results of the Health Risk Screening (HRS)
- From internal and external referrals

We refer identified members to the Care Management team for assignment to a CM and completion of the Health Risk Assessment (HRA). The HRA is a comprehensive clinical assessment using structured instruments available in the CM documentation system. The CM assesses the member's total health care needs in a holistic manner, including their physical health, BH, functional, cognitive, and social needs. As part of the assessment process, the CM completes a "gap analysis" to identify needed services and supports, including services furnished by DHHS-administered programs or available from other funding streams (such as Medicare), community resources, and the priority for each. They focus on approaches to mitigating gaps in care and in connecting members to alternative services and supports, including telehealth options. In addition, because unmet SDOH may contribute to difficulty access timely care, they help members find community resources and use the Community Resource Link platform to complete and track referrals to local programs, agencies, and CBOs.

The CM develops a care plan in collaboration with the member (or the member's representative), the member's PCP, and other key providers with member consent within 30 calendar days of completion of the HRA. Using information gathered through the assessment process, including a review of relevant evidence-based clinical guidelines, the CM develops an individualized care plan. This plan includes the member's prioritized goals and preferences, interventions designed to assist the member in achieving these goals, and identification of barriers and challenges to meeting goals or complying with the care management and/or provider care plan. The CM coordinates services needing Healthy Blue authorization with the UM team and works with external case managers or services coordinators to promote collaborative care planning and exchange of information as allowed by HIPAA and with member consent.

Preventing Readmissions

Because discharge and transition represent a period of heightened risk for our members, we implement ***discharge care management*** immediately following a member's hospital admission. Our CMs and UM Clinicians collaborate with the member, family or caregiver, and hospital discharge planners, to develop and implement a discharge plan. The plan includes member education, arranging services and supports needed to support discharge home or to the next level of care, completing medication reconciliation, making follow-up calls after discharge to confirm members are receiving needed services and supports, and connecting members to specialized services designed to prevent readmission. They continue enhanced follow-up with weekly check-ins for at least 30 days post discharge.

[redacted]

Preventing Behavioral Health Inpatient Readmissions. A Healthy Blue psychiatric nurse CM calls our major hospitals daily to identify members who need additional assistance with discharge planning. Our BH UM team meets three times weekly with the BH Clinical Director and our BH CMs assigned to specific hospitals to discuss the needs of members who have frequent and rapid readmissions or who have delayed discharges. They share real time information as members transition from inpatient to community care, troubleshoot barriers to timely discharge, and identify specialized providers and other services and supports that will be available upon discharge. Once members are discharged, they are assigned to a CM in their area who follows up immediately to secure an outpatient BH follow-up appointment within seven days of discharge, with a check-in and follow-up within 30 days of discharge. [redacted]

Targeted Interventions for Members with Asthma

Our comprehensive approach to supporting members with asthma informs and educates members and providers on the management of asthma, including the appropriate use of controller medications and rescue inhalers and ways to reduce allergens. Interventions include member self-management support, connection to services and community resources, and application of evidence-based interventions demonstrated effective in improving asthma management and associated outcomes. [redacted]

Asthma Condition (Disease) Management. We offer structured condition management programs focused on managing chronic disease, reducing acute episodes and disease complications, improving members' quality of life, and reducing health care costs relative to an illness. Members with asthma may enroll in our asthma condition management program that incorporates member, family, and provider interventions. Our CMs support each member's understanding of their conditions, medications, and risk factors and provide daily reminders. They connect members to telehealth and our telehealth kit, as well as VAS to support self-management. We are developing initiatives to increase early identification of asthma so members can readily receive diagnostic evaluations and treatment to better control their symptoms and improve their quality of life. We will focus on engaging members with asthma living in in rural areas in case management to help them achieve their care plan goals. Additionally, we offer members health education about asthma at our Welcome Rooms.

[redacted]

Targeted Interventions to Address Members' Dental Complaints

Members with dental complaints, such as tooth pain, the need for orthodontia, and poorly fitting dentures, who are unable to access a dental provider quickly or are uncertain about dental coverage, may contact our Member Services Call Center and will be connected to either the dental vendor or our Care Management team depending on the extent of their dental needs. In addition, if we identify an ED visit with an associated oral health diagnosis code, our Care Management team contacts the member to identify the reason for the ED visit and connect the member to the dental vendor for assistance when indicated. As we transition to the new contract period with the carve-in of dental benefits, we will implement several initiatives with our partner Liberty Dental focused on preventing dental issues and rapidly addressing dental complaints when they do develop to reduce the likelihood a member will visit the ED for oral health-related needs. Healthy Blue's Chief Medical Officer will collaborate with Holly Randone DDS, our Dental Director, to refine and coordinate our overall oral health strategy and to help facilitate members' access to comprehensive, whole person health care. We describe our overarching approach to managing dental benefits in our response to Section V.E.23.

Through the ***Dental Home program***, administered by Liberty Dental, all members will be assigned to a Primary Care Dentist (PCD). Members and providers will be informed of how to contact Liberty Dental to locate a PCD, the assistance available from Liberty Dental, and the availability of our Care Management team to assist with member's complex health care conditions that include dental complaints. Our Care Management team will work closely with Liberty Dental to coordinate the needs of members with dental complaints who need specialized management because of their complex care needs. For example, we will collaborate to address the reasons a member seeks oral health-related care in the ED and coordinate care for our members with Special Health Care Needs who require anesthesia during dental procedures or inpatient dental surgery including coordination of needed authorizations and post-surgical management. ***Members will also have access to teledentistry*** that will provide 24/7 on-demand access to preventive and urgent dental services. Following teledental visits, we will refer the member back to their Dental Home to assure continuity of care. We will also bring ***mobile dental services*** to a high-volume PCP office on a clinic day or introduce mobile dental units to schools in communities with the greatest needs. We will partner with organizations such as Midtown Health Center Federally Qualified Health Center in support of their existing mobile dental unit and OneWorld Community Health Center to deploy mobile dental services to areas where achieving access standards can be challenging.

Targeted Interventions for Members with Chronic Pain

Healthy Blue **contracts with Aspire to provide palliative care** for patients with serious illnesses with a goal of improving the quality of life for the member and their families. Our Care Management team works closely with the Aspire care team to assure members' needs are met and that services are delivered in collaboration with the member's PCP and specialist physicians. Members may be referred for palliative care by their PCP or specialty provider, including inpatient or skilled nursing facility provider. Palliative care is specialized medical care that focuses on providing relief from pain and other symptoms of a serious disease, no matter the diagnosis or stage of disease. [redacted]

Targeted Interventions for Members with Mental and Behavioral Health Conditions

All previously described interventions are available to members with mental or BH conditions as applicable to their specific needs. Through Nebraska's Health Information Exchange, CyncHealth, we receive timely notification of members hospitalized for inpatient psychiatric care at Immanuel, Lasting Hope or Bryan hospitals, supporting rapid member outreach, engagement, and connection outpatient care before discharge. We offer several Medication Management Programs designed to prevent unnecessary ED visits and hospitalizations, including outreach to members (and alerts to the Care Management team) when members fail to fill medications. In addition, we offer several initiatives focused on members with substance use disorder (SUD). [redacted]

No. 86

Healthy Blue's MTM Program

Healthy Blue's Medication Therapy Management (MTM) program works to optimize therapeutic outcomes for targeted Medicaid members through identification and resolution of drug therapy issues, improved medication adherence, cost-effective medication use, and reduction of adverse medication events. The MTM program identifies members with suboptimal use of medications, including incorrect dosage, over- and underutilization, coordination of care issues that result from multiple prescribers, polypharmacy, non-conformity with national guidelines, and potentially inappropriate management of chronic conditions or untreated disease states. Members may also be identified for a comprehensive medication review (CMR). MTM services may include telephone, fax, or mailing outreach to member and/or providers.

Healthy Blue's MTM program is designed to carefully analyze historical drug utilization and identify opportunities to encourage clinically appropriate utilization based on various disease states, such as diabetes, asthma, behavioral health (BH), etc. Collectively, these programs make up our MTM program. Under our integrated MTM program, a Clinical Pharmacist or Pharmacy Technician communicates with the member, prescribers, and caregivers — closing gaps in care and optimizing therapies for members who have chronic conditions. Member counseling interventions based on proprietary predictive models assure that at-risk members receive the right message at the right time to effect positive changes in their medication-taking behavior. We work to assure that each prescription and nonprescription medication is reviewed and determined to be:

- Appropriate for the member
- Effective for the medical condition
- Safe, given the complexity of the member's current physical health status
- Able to be taken by the member as intended to improve medication adherence and clinical outcomes

The MTM model can be used for managing members with multiple medical conditions (comorbidities) and members who require multiple medications to manage their conditions. It can also be targeted for members with specific chronic illnesses such as diabetes, cardiovascular disease, asthma, and depression — each of which often require multiple medications for management.

To provide optimal therapy and produce positive outcomes, the clinical pharmacist uses a systematic approach to deliver medication management services. These services may include:

- **Comprehensive Medication Review.** Data CMR completed by pharmacist, which consists of review of appropriate medication regimen (for example, omissions, suboptimal therapy), safety concerns (for example, drug-drug interactions, polypharmacy/duplicate therapy), assessing potential medication-related problems (for example, side effects), compliance with national guidelines for Disease Management, etc., with appropriate physician and/or member follow-up as necessary.
- **Messaging to Providers by Fax.** We send care gap messages by fax to providers alerting them of specific care gaps individualized to their patients.
- **Using Our Opioid Prescriber Report.** A summary report of providers' opioid prescribing practices that compares prescribers to peers. The information is provided in the form of a report card to educate on their prescribing patterns and offers multimodal support to reduce the opportunities for opioid misuse and abuse among members. Our Pharmacy Benefits Manager (PBM) also leverages this report to identify potential fraud and abuse of controlled substances by prescribers.

In addition, we:

- Assist members in understanding their prescriptions, providing education about their medication, and engaging members in efforts to improve their compliance with prescribed medication regimens.
- Educate members about how to effectively communicate their preferences and needs with their prescribers to promote shared decision-making.
- ***Assess prescribing patterns and treatment plans*** involving psychotropic medication, opioids, medications at risk of abuse, high-cost medications, and other medications identified by DHHS or Healthy Blue.
- ***Track activities and results*** associated with outreach, using various outcomes dashboards and monitoring tools. These outcomes are summarized with a presentation provided quarterly and with a final year-end report.
- Use ***analytics and reporting*** to track high-need members and refer to case management. We are expanding on our process to refer members identified with the MTM program, such as those with polypharmacy, multiple prescribers, adherence issues, and care gaps following hospitalization for a COPD exacerbation, to the care management team.
- Use ***results of DUR program analysis to improve MTM education and intervention***.
- Will submit an annual report to DHHS that describes our MTM program activities, the relative effectively of our efforts, and our planned activities for the next reporting period.

Vendors Used to Administer MTM Services

Our MTM program is administered through our affiliate PBM, IngenioRx. We collaborate to develop programs that are reactive and responsive to State goals and feedback, customize reporting for the health plan, implement new programs as developed, and revise existing programs as needed to best meet member needs. We continually gather data to inform the rules and parameters of our programs and to assure we are responsive, reactive, and proactive in our programming. Our PBM has provided MTM services for us since we transitioned to IngenioRx on January 1, 2021, and for the past three years for our affiliate markets. IngenioRx currently provides MTM services in 15 affiliate markets.

MTM-specific Inclusion Criteria and Tools

We use comprehensive algorithms to analyze claims for utilization trends and identify providers with outlier prescribing patterns relative to their peers, or patterns of fraud, waste, and abuse (FWA), or inappropriate, medically unnecessary, or excessive use of medications by members, providers, or pharmacies. These findings help us to educate providers and members and emphasize the practice of clinically sound, cost-effective medication use. We also analyze provider prescribing patterns by stratifying pharmacy claims data to track prescribing and usage patterns and trends. This includes programs as required by the SUPPORT Act.

Healthy Blue's targeted condition-specific inclusion criteria and interventions are discussed next.

Diabetes Polypharmacy

Inclusion criteria: [redacted] Table V.N.86-1 lists the specific interventions.

Table V.N.86-1. Healthy Blue's Diabetes Polypharmacy Program Interventions.

Diabetes Polypharmacy Intervention	Description
[redacted]	[redacted]

BH Medication Management

Inclusion criteria: [redacted] Table V.N.86-2 lists the program's specific interventions.

Table V.N.86-2. Healthy Blue's BH Medication Management Program Interventions.

BH Medication Management Intervention	Description
[redacted]	This program is designed to reduce the instances of children and adults receiving: [redacted]
[redacted]	[redacted]
[redacted]	Identifies members who are prescribed multiple psychotropic medications from multiple prescribers to: [redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Controlled Substance Utilization Monitoring

Inclusion criteria: [redacted] Table 86-3 provides details on some of the thresholds used to identify members at risk under this program.

Table V.N.86-3. Healthy Blue's CSUM Program Thresholds.

CSUM Threshold	Description
[redacted]	[redacted]

CSUM Threshold	Description
[redacted]	[redacted]

Our PBM relays information on identified members to the prescribing providers to alert them, and to ask them to engage these members, given their risk for adverse events related to controlled substance and opioid misuse. The CSUM program helps to coordinate care and reduce risk of controlled substance overutilization and results in decreased high-dose opioid use and decreased doctor and pharmacy shopping. It also reduces FWA by addressing drug-seeking behavior and doctor or pharmacy shopping.

Asthma Medication Program

Inclusion criteria: [redacted] Table V.N.86-4 lists the specific interventions.

Table V.N.86-4. Healthy Blue's Asthma Medication Program Interventions.

Asthma Medication Intervention	Description
[redacted]	[redacted]

These programs result in more informed prescribers and members, increasing the safety and effectiveness of medication therapies and leading to improved member health outcomes.

Medication Adherence-related Programs

Inclusion criteria: [redacted]

Core intervention includes medication adherence outbound member calls for oral diabetes, and targeted antihypertensive and cholesterol medications (statins). Table V.N.86-5 lists the specific interventions.

Table V.N.86-5. Healthy Blue's Medication Adherence-related Program Interventions.

Medication Adherence Intervention	Description
[redacted]	[redacted]

Medication Adherence Intervention	Description
[redacted]	[redacted]

Medication adherence is also addressed on the provider side through adherence notifications and a faxing program to promote extended fills (60 to 90 days) for specific drug classes when allowed.

With support from the pharmacy analytics team, the pharmacy services program will evaluate the success of these programs in improving member medication use with consequent improvement in outcomes by comparing cohorts of members who did and did not receive MTM services.

[redacted]

Active Engagement of Retail Pharmacies

One means by which we engage our pharmacists is through our Prospective Drug Utilization Review (ProDUR) program, which uses information technology to proactively alert the dispensing pharmacist to potential drug risks or other clinical information relevant to appropriate dispensing of medication at the point of sale (POS). Our PBM has a system for POS communications to identify and classify drug-to-drug interactions by severity. During the pharmacy claim adjudication process, our PBM's system automatically notifies the dispensing pharmacist of specific concerns when the claim meets drug specific severity thresholds. The system alerts the dispensing pharmacist for potential drug-disease interactions, drug dose (high or low), drug patient precautions (age, gender, pregnancy, etc.) and over or underutilization.

[redacted]

No. 87

Healthy Blue DUR Programs Work to Assure Appropriate Medication Utilization

Together with our Pharmacy Benefits Manager (PBM), IngenioRx, ***Healthy Blue's comprehensive Drug Utilization Review (DUR) programs address over- and under-utilization of prescription medications and include both Prospective DUR (ProDUR) and Retrospective DUR (RDUR)***. DUR helps verify appropriate drug use based on safety guidelines and current evidence-based, industry-standard drug therapy practices.

Our Pharmacy Director, Shannon Nelson, Pharm D, manages and oversees the prospective and retrospective DUR activities. We operate our DUR program in compliance with State and federal requirements and provide reports in the required format and timeframe. We will submit processes and procedures for these programs for review and approval at least 90 calendar days prior to the new contract or implementation of any changes. As part of our program, we will also monitor for off-label drug usage, conduct drug criteria analyses, and evaluate the effectiveness of interventional education programs for members, prescribers, and pharmacies.

We operate our DUR program through a cross functional, interdisciplinary approach that involves coordination across departments and functional areas. We assess program effectiveness through retrospective, member-level analyses, and cost impact. Our DUR program aligns with our goals of promoting member health and safety, improving member and provider experience, and helping keep health care affordable. The standards and criteria used in RDUR and ProDUR are based on Medi-Span (drug compendium) information, clinical guidelines, best practices, and FDA-approved manufacturer drug labeling.

Prospective Drug Utilization Review

ProDUR standard edits are applied to all pharmacy claims, including behavioral health (BH) and substance abuse drugs, as well as medications used to treat physical health issues. In support of patient safety, our ProDUR program uses information systems to proactively alert the dispensing pharmacist to potential drug risks or other clinical information relevant to appropriate dispensing of medication at the point of sale (POS). Our PBM has a system for POS communications to identify and classify drug-to-drug interactions by severity. During the pharmacy claim adjudication process, our PBM's system automatically notifies the dispensing pharmacist of specific concerns when the claim meets drug specific severity thresholds. The system alerts the dispensing pharmacist for potential drug-disease interactions, drug dose (high or low), drug patient precautions (age, gender, pregnancy, etc.) and over- or under-utilization.

Our ProDUR follows the National Council for Prescription Drug Programs standard formats for conflict, intervention, and outcome. The program reviews all prescriptions, compares them to patient demographics, and checks for potential clinical conflicts that may result if the prescription is dispensed. These include drug-drug interactions, drug-allergy or drug-disease conflicts, early refills, therapeutic duplication, maximum and minimum daily dose, under- or over-utilization, drug, age, gender, and pregnancy conflicts. A message is conveyed to the pharmacy regarding any issues identified and pharmacists can enter override codes for less severe issues, where more severe interactions have a hard stop that requires authorization before claims adjudication can be completed.

We adjudicate pharmacy claims via an online, real time, rules-based POS system, using one integrated claims processing system. A single system provides retail, specialty, and home delivery pharmacies with consistent, integrated member information. The platform also brings together member, physician, pharmacist, and drug data for administrative and DUR edits. This assures accurate and efficient claims processing. The online POS system allows participating pharmacies to submit prescription drug claims electronically 24/7 and adjudicates these claims in real time. Our PBM's claims processing system performs eligibility verification, claim adjudication, provider validation, duplicate claims edits, and DUR edits online in real time. This single platform POS technology maintains complete member history and instantly updates plan and eligibility specifications. In doing so, the system monitors for duplicate prescriptions, therapeutic overlaps, and screens for early refills.

The online claims processing system runs a series of online claims verification and authorization edits before adjudicating a claim. Applied at the POS, these edits act as an automated management tool to verify compliance with program parameters and prevent duplicate prescriptions or therapy before a prescription is dispensed. The system alerts pharmacists to potential adverse consequences at dispensing, including drug interactions. The Drug Interaction rule identifies potential problems with conflicting drug therapies. Comparing the incoming National Drug Code (NDC) to a table of interacting drug identifies this rule. If the incoming NDC is on the table, the system will identify other drugs that interact and review the patient profile for current interacting drugs. ProDUR combines vendor-supplied drug database safety rules and our internal rules to review prescriptions for member health and safety. Based on this, we determine whether to send a warning (passive alert), a reject message that requires manual override at POS (soft-block alert), or a reject message that requires Healthy Blue authorization (hard stop reject). Table V.N.87-1 details examples of the types of ProDUR edits.

Table V.N.87-1. Our DUR Edits Enhance Member Safety and Facilitate Appropriate Utilization and Formulary Compliance.

Category and Name	Edit Category and Description
Safety	
Drug-Drug Interaction	Checks member's prescription history for interactions between two or more drugs as determined by Medi-Span Drug Therapy Monitoring System
Drug-Disease Interaction	Determines whether the submitted drug conflicts with the member's health status
Drug-Pregnancy	Identifies contraindications of the new drug claim against those in the member's history (inferred pregnancy based on drug history)
Age Limitation	Identifies age contraindications based on FDA-approved labeling
Gender Edits	Identifies contraindications based on the member's gender
Therapeutic Duplication	Identifies duplications by therapeutic class or ingredient and time period
High-Excessive Dosing	Identifies drugs prescribed for use beyond the manufacturer's recommendations for length of therapy or maximum daily dose

Low-Minimum Dosing	Identifies drugs prescribed for use below the manufacturer's recommendations for length of therapy or minimum effective daily dose
Utilization	
Early Refill	Grants a refill once 90% of the previous supply is used; if the time frame has not passed, requires prior authorization
Under-utilization	Identifies potential non-compliance based on previous claim history
Formulary Compliance	
Step Therapy	Requires use of first-line medication before authorizing a non-preferred or second-line agent

Retrospective Drug Utilization Review

Our RDUR programs use comprehensive algorithms to analyze claims for utilization trends and identify providers with outlier prescribing patterns relative to their peers, or patterns of fraud, abuse, or inappropriate, medically unnecessary, or excessive use of medications by members, providers, or pharmacies. RDUR findings help us to inform providers and members on appropriate medication use. Using robust medication management strategies, we identify and manage utilization patterns (such as polypharmacy) while also monitoring for potential abuse or inappropriate use of controlled prescription medications. Through periodic reviews of pharmacy and medical claims data, we identify potential cases of drug use or misuse, under- and over-utilization, and coordination of care issues. We also analyze provider prescribing patterns by stratifying pharmacy claims data to track prescribing and usage patterns. We focus on high-risk conditions to assure better health outcomes and overall cost of care savings, such as:

- BH: Depression, ADHD
- Cardiovascular Diseases: Hypertension, Hypercholesterinemia
- Diabetes
- Pain Management/Controlled Substance Utilization Management
- Respiratory Diseases: Asthma, Chronic Obstructive Pulmonary Disease (COPD)

SUPPORT Act Compliance

In compliance with the SUPPORT Act, we implement safety edits at the POS for duplicate and early fills, quantity limits, dosage limits, and morphine milligram equivalents (MME), such as:

- A PA safety edit for early fills or when drug quantity limits are exceeded. The pharmacist at POS cannot override the edit and the pharmacist notifies the provider about the PA requirement.
- A soft-block edit for duplicate therapy which can only be overridden by the pharmacist when, using their professional judgment, determines that dispensing the prescribed medication would not jeopardize the health or safety of the member.
- A PA safety edit when the daily dose of opioid is greater than or equal to 90mg MME. The pharmacist at POS cannot override the edit and notifies the provider about the PA requirement.
- A soft edit that sends the pharmacist a message regarding the safety concern of concurrently prescribed opioids and antipsychotics.

The following programs are currently running to monitor the use of antipsychotics for child members:

- **Appropriate Metabolic Screening.** Identifies children and adolescents one to 17 years of age who had two or more antipsychotic prescriptions and did not have metabolic testing during the measurement year.
- **Appropriate Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics.** Identifies members who filled antipsychotic medication but did not receive psychosocial care in the 90 days before or 30 days after filling the prescription.
- **Child Age-Appropriate.** Monitors inappropriate prescribing for children under age six being prescribed antipsychotics, stimulants, and antidepressants, as the use of medications outside of clinical guidelines and specifications can lead to increased risk of complications and adverse effects in this population.
- **BH Polypharmacy.** Monitors for children taking multiple (or duplicate therapy with) antipsychotics or use of multiple psychotropic medications in children (includes antipsychotics and other psychotropic medications).

Through our processes and proprietary algorithms, we review pharmacy claims to detect patterns of potential fraud, waste, and abuse (FWA) of controlled substances by Medicaid members, health care providers prescribing drugs, and dispensing pharmacies.

Prescriber Education and Outreach

Healthy Blue and our affiliate PBM, IngenioRx, also provide an array of prescriber education programs, including:

- PDL education, availability, compliance, and PA processes
- Appropriate use of meds
- Condition specific letters/faxes, such as diabetes, COPD, asthma, BH
- Newsletters regarding changes and updates to our pharmacy program
- Formulary changes
- Medication recalls
- RDUR outreach

Restricted Services Program. As part of our Restricted Services program, we complete member reviews related to their medication use and send personalized letters to providers when there are concerns. We also conduct MME reviews through our Restrictive Services Interdisciplinary Committee focusing on members with high opioid activity to assure communication exists between multiple prescribers. This integrated clinical team reviews BH, medical, and pharmacy information to identify and address needs of members who may otherwise not receive needed attention.

Claims Surveillance. Our PBM's proprietary claims surveillance program reviews claims to make sure they adjudicate according to the benefit design. It uses algorithms and leverages analytics that identify outliers to recognize opportunities for better medication and disease state management. It detects member-specific medication and disease management opportunities that are actionable, such as letters to providers, care management referrals. We identify provider prescribing patterns that may result in provider education, SIU

referrals, or additional monitoring. We also identify potential areas to improve POS coding to optimize claims adjudication accuracy. This continual surveillance allows for prompt adjustments to the coding and optimizes claims adjudication accuracy. This process produces efficiencies in cost of care by maximizing the cost-effectiveness of benefit delivery.We follow up with providers with prescribing alerts, letters, educational materials, and peer-to-peer consultation when surveillance detects member safety concerns. Our goal is not to infringe on providers' decision-making practices, but to provide education and training on best practices for prescribing medications to support prescriber self-regulation. Education helps providers make care decisions based on the latest medical evidence. Further, when a member is referred to care management, the Care Manager outreaches to the member's prescriber to discuss coordination of care and medication compliance.

Opioid Prescriber Report. Information is provided to prescribers in the form of a report card to educate them on their prescribing patterns and offers providers multimodal support to reduce the opportunities for opioid misuse and abuse among their members.**Pharmacy Data.** We leverage pharmacy data to identify Provider aberrant prescribing and billing patterns and use this information to educate prescribers and identify and report potential FWA to our SIU for further investigation.

Pharmacy Education and Outreach

Healthy Blue uses clinical program pharmacy outreach activities and pharmacy fax blasts for formulary changes, claim adjudication changes, legislative changes. We also use the POS DUR Activity Report that summarizes prescriber outreach efforts. POS Safety Review utilizes a series of edits designed to check the plan member's prescription history for possible drug conflicts and safety issues. When a claim is adjudicated, pharmacy claims systems evaluate the complete patient drug history and send real time alerts to the dispensing pharmacist every time a safety issue is triggered. The report tracks response rates, the top reported drugs and the top 25 prescribers. As discussed previously, our pharmacists can receive alerts at POS for potential drug-disease interactions, drug dose (high or low), drug patient precautions (age, gender, pregnancy, etc.) and over or underutilization.

Collaboration with MLTC's DUR

Healthy Blue has a strong history of collaboration with the State DUR program. Specific efforts include:

- Providing data to help steer current and future projects
- Providing ideas and suggestions for new initiatives
- Identifying drug classes with potential overutilization for future DUR reviews
- Working to identify opportunities for changes to PA criteria
- Actively participating in DUR Board meeting discussions and initiative development

Recognizing that our programs can drive ideas for all Nebraska Medicaid, our programs must also help the State DUR program. Our Pharmacy Director, Shannon Nelson, represents our pharmacy program at DHHS-scheduled DUR Board and the DHHS Pharmacy and Therapeutics (P&T) Committee meetings. She brings initiatives and recommendations to the DUR Board for consideration.

DUR Results Can Inform MTM Education and Outreach

The pharmacy department analytics team analyzes data and generates operational, financial, and clinical reports as needed. Operational reports measure key metrics pertaining to pharmacy claims and prior authorization to fully understand changes in drug utilization and spending patterns. Clinical prescription data analysis and reporting evaluate cost, utilization, and general drug trends. These insights support development of new clinical MTM programs that result in education and outreach to our providers and members.

In addition to standard reporting, ad hoc analyses are also routinely performed to support strategies related to formulary optimization, PA, pharmacy appeals, clinical programs, network reimbursement, and other contractual obligations. With support from the IngenioRx Pharmacy Analytic team, the pharmacy services program evaluates the success of these programs in improving member medication use with consequent improvement in outcomes, by comparing cohorts of members who did and did not receive MTM services. These outcomes and results then are used to drive decision-making to make process improvements with our MTM program, such as updating targeting criteria, utilizing different timeframe for outreaches, or making changes to the workflows. Our MTM program also pairs well with utilization management trends, using that information to identify new outreach programs.

Examples of using DUR results to inform MTM education and outreach include:

- **Asthma Program.** Uses highly specified targeting of outreaches with our MTM program. Outcomes have driven the targeting design to maximize impact on the Asthma Medication Ratio (AMR) HEDIS measure, targeting different AMR ranges at different times of year. Additionally, data has driven specific targeting with our educational outreaches for members newly starting asthma medications.
- **Child Age-Appropriate Program.** Data identified continued use of targeted drug class in children under six, despite utilization management strategies already in place. This program works in collaboration with edits and other initiatives, to perform higher touch outreach with members less than six years old receiving ADHD, antidepressants, or antipsychotic medications. The prescriber is outreached with member-specific information via fax and followed up with a phone call. The goal is to identify a decision maker for the member and discuss the safety of those medications used in children. Data through Q3 2021 showed that ***91% of targeted members were discontinued off the targeted medications***.

No. 88

Healthy Blue's Comprehensive Psychotropic Drug Oversight Program Assures Appropriate Utilization

Together with our affiliate Pharmacy Benefits Manager (PBM), IngenioRx, Healthy Blue uses a suite of programs and processes to monitor and manage for appropriate use of psychotropic drugs. In the following sections, we will outline our efforts. Our programs meet the psychotropic drug requirements in SOW Section N and other requirements regarding psychotropic drugs in SOW Sections L and E.

Our Psychotropic Drug Oversight program consists of:

- Prospective Drug Utilization Review (ProDUR) edits perform real-time drug utilization analysis at the point of prescription dispensing for psychotropic drugs
- Prior authorizations (PAs) including ePA processes to allow continuity of care for psychotropic drugs when appropriate
- Retrospective Drug Utilization Review (RDUR) analysis and outreach
- Multiple other tools to monitor and measure
- Processes to actively engage retail pharmacies and pharmacists
- Prescriber and pharmacy interventions
- Processes to assure appropriate prescribing for children

We use targeting criteria, like the following, to focus on and monitor the appropriate use of psychotropic medications:

- Members with multiple prescribers or psychotropic medications to address polypharmacy
- Inappropriate prescribing for children under age six
- Duplicate therapies for multiple antipsychotics
- Use of multiple psychotropic medications, including antipsychotics, stimulants, antidepressants, mood stabilizers, anxiolytics, and sedative hypnotics

Prospective Drug Utilization Review

Our ProDUR edits perform real-time drug utilization analysis at the point of prescription dispensing for psychotropic drugs. Each electronically transmitted claim is reviewed to identify pertinent clinical safety or utilization concerns and generates an alert to the dispensing pharmacist in real time before the member receives the prescription. Our PBM's Point of Sale (POS) claims payment system applies stringent online electronic claims verification and authorization edits, while allowing immediate claims payments when no concerns are identified. ProDUR reporting is utilized to identify trends that may drive future clinical programs.

We assure that the State utilization edits regarding psychotropic drugs are applied appropriately by using ProDUR POS edits. The POS system is easily reconfigurable when new drugs and diagnoses are added or removed, or when any associated utilization management (UM) criteria is updated. We use age- and dose-limit edits to assure safe use of psychotropics. Requests for medication outside of the age and dose limits are referred for PA for further in-depth review, discussed in more detail later in this section. Our PBM structures PA criteria within the POS system, with effective dates for the system to apply benefits appropriately based on dates of service.

Experienced adjudication coders confirm that the preferred drug list (PDL) is updated accurately and in compliance with requirements. We incorporate quality assurance checks within the formulary coding process at multiple points to assure accuracy and our ability to adjust coding promptly when necessary to adhere to the PDL and pharmacy benefit design. We make sure that the real-time POS process system incorporates updates. Our PBM verifies claims for formulary compliance, eligibility, drug coverage, plan design, and ProDUR upon receipt. The system applies hundreds of edits within seconds, based on eligibility requirements and benefit design, and concurrently delivers targeted alert messaging to dispensing pharmacists. Continuity of care processes are used to assure members taking antipsychotic medications may continue to take them without facing unnecessary barriers. We use a claim lookback process to determine if a member has taken a particular antipsychotic in the past, and if so, they bypass any requirements based on drug non-preferred status. We apply safety edits to assure appropriate and safe drug use. The POS DUR Activity Report summarizes prescriber outreach efforts.

Retrospective Drug Utilization Review

RDUR analysis is performed through a review of pharmacy claims on a daily, weekly, and/or monthly basis as appropriate. RDUR letters are faxed or mailed to targeted prescribers and members to identify gaps in care, discuss adherence, and identify potential under-and overutilization, drug abuse or misuse, and/or improve formulary compliance. Some members are referred to the Restricted Services program or to a pharmacist for further evaluation or clinical intervention. RDUR results are shared with health plan leaders on an ad hoc basis or at a minimum of quarterly on a scheduled basis. RDUR details are also presented during plan-specific quality management (QM) meetings and/or DUR Committee meetings.

Tools for Monitoring and Measuring Psychotropics

We use a variety of tools to monitor and measure psychotropic prescribing patterns, including:

- **Proprietary Algorithms.** Through our RDUR program, we use algorithms that identify members who are taking prescriptions that fall outside of current guidelines, have stopped taking prescribed medications, or have experienced gaps in refills. These metrics are used to reach out to providers to address potential issues if drug therapy regimens indicate overutilization, underutilization, or drug safety issues. Our PBM also contacts members directly to address certain medication adherence concerns.
- **PA Reporting.** Our PA reporting monitors PAs requested and approved.
- **ProDUR Edits.** ProDUR edits monitor at POS.
- **Predictive Modeling Tools.** Our care management team uses a suite of analytic tools to identify risk level for members, including those with high-risk, complex behavioral health (BH) conditions, multiple medications, and repeated emergency department (ED) use. These tools help us predict the care members need and take proactive steps to assure care is accessible and available. For example, our Maintenance Medication Adherence Report identifies indicators of underutilization, overutilization, and possible opioid use disorder (OUD), and our First-time Admission Report identifies indicators of BH issues that may result in a future admission.
- **Grand Integrated Rounds.** Comprised of Medical and BH Directors, a Pharmacy Director, CM and UM Clinicians, QM staff, a Substance Use Disorder (SUD) Specialist, and Medication Management Specialist, who work together to assist Care Managers (CMs) in monitoring members' medication and care coordination needs through weekly case conferences, including BH-specific

case conferences that oversee members with complex BH conditions. Our CMs have specialized training in medication monitoring and work daily with our Pharmacy Director for coordination concerns.

- **BH Case Management Activities.** The BH case management team receives a weekly report of all members missing the refill of an antipsychotic and/or SUD Medication-Assisted Treatment (MAT) prescription. Local BH Outreach Care Specialists call each of these members to problem-solve barriers to receiving medication and offer case management services.
- **Care Management Activities.** We integrate our daily pharmacy file into our case management system, for easy access by CMs who oversee the delivery of services to members with BH needs. Providers have access to this information through our provider portal. Our CMs also access CyncHealth for real-time pharmacy data to monitor medications for members with high-risk indicators, such as those transitioning from inpatient services. CMs use this information during collaboration with those involved in the member's care, such as providers, prescribers, and targeted case management and caseworkers. Our CM team also analyzes claims and encounters data to identify members with under- and overutilization, such as those with unfilled prescriptions and prescriptions from multiple providers.
- **Review of Data to Identify Members Taking Psychotropics.** We receive a report of members participating in the following initiatives who have been placed on an antipsychotic or are taking psychotropics and conduct outreach if they are not filling those prescriptions:
  - **Post-Discharge Management (PDM) Program.** Team works with members and families, PCPs, hospital discharge planners, social workers, providers, and UM Clinicians to support the member's discharge plan. This includes pre- and post-discharge activities, such as medication reconciliation and education on the importance of medication adherence.
  - **Medication-Assisted Treatment.** In collaboration with our CM and UM teams, our CMs oversee and monitor the medication management of buprenorphine and other prescribed medications for substance use MAT when they are provided by PCPs, hospital facilities, EDs, and other contracted medical settings.
  - **Screening, Brief Intervention, and Referral to Treatment (SBIRT).** We encourage and incentivize providers to complete the SBIRT screening at routine and preventive appointments. This offers an opportunity to identify members taking multiple prescriptions from multiple prescribers or that may have adverse side effects when taken together. CMs follow up to make sure members receive education on prescriptions and close the loop on referrals to services, such as psychiatric or MAT.
- **UM Committee.** Comprised of our Chief Medical Officer, BH Clinical Director, and local physical health and BH providers, who meet quarterly to review our quality improvement (QI) and health equity activities. This includes conducting peer reviews and monitoring practice patterns and drug utilization to verify appropriateness of care and improvement/risk prevention activities, including review of clinical studies and development and approval of action plans and recommendations for QI studies.

Quality Assessment and Performance Improvement Committee (QAPIC)

This team also reviews pharmacy reporting to identify utilization trends and patterns, which are reported to our QM Committee. This supports our review of medications prescribed and facilitates prompt discussion of issues or concerns with our Medical Directors, who collaborate with providers to reconcile as warranted.

Pharmacy Workgroup. This workgroup is comprised of local Medicaid QM Coordinator, Pharmacy Directors, and IngenioRx Clinical Program Pharmacists to review and develop pharmacy clinical programs interventions, share best practices, review the impact of programs on specific quality measures, and identify trends or program improvements based on results. Examples of HEDIS metrics monitored include metabolic monitoring for children on psychotropic and use of first-line psychosocial care for children and adolescents on antipsychotics.

We monitor prescribing patterns through the quality of care process and initiate corrective action plans with providers when issues are identified. This is also monitored through the QAPIC and Clinical Advisory Committee.

Process to Engage Retail Pharmacies and Pharmacists

Through our ProDUR edits, we alert dispensing pharmacies to potential drug therapy problems resulting from therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage, duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse. This provides important information to pharmacists to prevent adverse reactions, improves appropriate prescribing rates, and allows the pharmacist to assist with member counseling. In addition to member safety, POS edits identify providers who demonstrate aberrant prescribing patterns or who are on the federal or State exclusion list. Prescriptions written by excluded providers will not be paid under any circumstances. Further, [redacted]

Plans for Prescriber and Pharmacy Interventions

[redacted]

Interventions we use to reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member include the following:

ProDUR Edits for Pharmacy Interventions. This includes, for example:

- Drug-Drug Interaction edit that checks member's prescription history for interactions between two or more drugs as determined by Medi-Span Drug Therapy Monitoring System.
- Therapeutic Duplication edit that identifies duplications by therapeutic class or ingredient and time period.
- High Excessive Dosing edit that Identifies drugs prescribed for use beyond the manufacturer's recommendations for length of therapy or maximum daily dose.

BH Medication/Clinical Management Program. This program monitors and manages for appropriate use of BH medications (ADHD drugs, psychotropics, antipsychotics, polypharmacy, antidepressants, child age-appropriate drugs). As part of this program, we target members with multiple prescribers or psychotropic medications to address polypharmacy issues, as well as inappropriate prescribing of BH medications. Our program gives physicians feedback on their prescribing behaviors as compared to accepted standards of clinical practice or evidence-based treatment guidelines. Program goals are to reduce polypharmacy, promote medication adherence and

follow-up care, decrease inappropriate prescribing and use of psychotropic medications in children and older adults, coordinate care, and improve HEDIS performance.

Long-Acting Injectable Antipsychotic. We encourage the use of long-acting injectable antipsychotics to increase medication adherence, member safety, and quality of life. We use provider faxes to encourage use of long-acting injectable antipsychotic medication in schizophrenia patients who are non-adherent to oral therapies and have had recent schizophrenia-related hospitalizations.

Antipsychotic Medication Adherence Fax. Targets providers of members who are non-adherent to antipsychotic or bipolar medications with less than 80% proportion of days covered. The fax recommends suggestions for improving adherence and includes a medication refill history for antipsychotic medications to display level of non-adherence. [redacted]

Restricted Services Committee. Our interdisciplinary Restricted Services Committee reviews members identified with multiple controlled substances from multiple pharmacies and prescribers. As part of the restricted services reviews, we monitor and manage controlled substance utilization, including controlled substances used for ADHD and anxiety. Our team performs in-depth reviews of individual members' medical and pharmacy claims and refers members to care management for individualized member outreach. In cases where members are using more than one prescriber, individual provider letters are sent to assure communication between providers.

Use of Prior Authorizations for Psychotropic Drugs

IngenioRx administers pharmacy benefits in accordance with all applicable State and federal laws and regulations and has a process in place to allow member access to medically necessary non-preferred drugs. To this end, we require PA for psychotropic drugs prescribed to members under age 18. All PA requests for psychotropic medication outside of State age and dose limits for members under the age of 18 are reviewed by an ***in-house*** Nebraska-licensed child and adolescent psychiatrist. We also employ PA review to assure that providers have attempted a trial of psychotherapy before initiating psychotropic medications for the first time. For adults, we require PAs for any request that is outside of medication dose limits.

Prior Authorization Process. Our PBM offers multiple options for submitting pharmacy PA requests: electronically (ePA) through the web or from the provider's electronic health record (EHR), or by fax or phone, at no charge. Our PBM may require information for a PA, such as general member information, drug justification based on the member's clinical situation, planned course of treatment including duration, and drug quantity. To facilitate a prompt response to each authorization request, the PA team has real-time access to information about members' eligibility, medication history, diagnosis information from medical claims, and PDL benefit design. This integrated data is used when reviewing the PA request against the PA criteria. The clinical team follows current accepted guidelines, including treatment guidance from FDA-approved product package inserts, American Hospital Formulary Services, National Comprehensive Cancer Network, Clinical Pharmacology, DrugPoints®, DrugDex®, professional journals, and medical specialists when making recommendations regarding DUR edits, including PA criteria. We provide PA responses within the 24-hour requirement and offer at least a 72-hour emergency supply of medication without PA when appropriate.

We have implemented processes to reduce administrative burdens for providers, such as the implementation of automatic prior authorizations (AutoPA) and ePA, as discussed next.

AutoPA. AutoPA uses intelligent and automated logic that reviews integrated medical and pharmacy data against DHHS drug-specific PA criteria. Our pharmacy claims-processing system imports the member's diagnoses from medical claims system to approve PAs seamlessly when a medical necessity determination requires an appropriate diagnosis. If the medication meets medical necessity, the claim continues through the adjudication process. This functionality eliminates the need for the provider to submit a traditional PA request, making this process efficient and less burdensome for the provider and eliminating service delays for the member.

Electronic PA. The ePA programming logic identifies the member, determines if the prescription requires a PA, and presents the criteria to the provider in real time. The PA criteria question set has decision-tree logic to present only questions required to determine medical necessity. Once a provider answers all required questions, they submit the responses for medical necessity determination. When appropriate, the provider receives automatic approval. The ability to receive automatic approvals with ePA expedites the process, reduces administrative burden, and fosters positive member and provider experiences. ***ePA has removed member delays and allowed us to cut our average PA response time down to less than four hours, to provide quicker access to needed psychotropic medications.***

Processes to Assure Appropriate Psychotropic Medication Prescribing to Children

The following initiatives assure appropriate psychotropic medication prescribing to children:

ProDUR. Age Limitation edit that identifies age contraindications based on FDA-approved labeling.

BH Child Age-Appropriate Medication Program. Monitors inappropriate prescribing for children under age six for antipsychotics, stimulants, and antidepressants and alerts providers to potential risk of complications and adverse effects. We follow up with providers to help reduce inappropriate use of psychotropics, as the use of medications outside of clinical guidelines and specifications can lead to increased risk of complications and adverse effects in this population.

[redacted]

BH Polypharmacy Program. Monitors for children and adolescents, young adults, and adults with duplicate therapies for multiple antipsychotics or use of multiple psychotropic medications, including antipsychotics, stimulants, antidepressants, mood stabilizers, anxiolytics, and sedative hypnotics. We alert providers with a fax and follow up by phone to provide consultation on reducing polypharmacy and promoting medication adherence and follow-up.

MedReview Program. As part of this program, we monitor the prescription patterns for antipsychotics in children and adolescents and alert prescribers to member utilization and potential care gaps, promoting ongoing monitoring and follow-up care to assure safe and appropriate use of these medications. We send messages to providers so they can review current antipsychotic therapy for appropriateness and close gaps in care. This includes antipsychotics for children and adolescents, antipsychotics with no diagnosis or inconsistency with the diagnosis, metabolic monitoring for children and adolescents on antipsychotics, and antipsychotics with no psychosocial care.

ADHD Follow-up Care. Outreach addressing children started on ADHD medications. Includes a new start educational mailing, an automated phone call with disease/medication education, and a follow-up mailing emphasizing the importance of follow-up appointments. Provider outreach is also conducted to these address gaps in monitoring post-ADHD medication new starts.

Addressing Fraud, Waste, and Abuse

Our established processes identify potential fraud, waste, and abuse (FWA) of medications by members, providers, and pharmacies through systematic review of aberrant patterns of prescription filling, multiple prescribers, and approvals of drugs that require a higher level of review. Our program identifies and manages FWA through ongoing, targeted interventions and investigations. This includes a process to identify potential FWA of controlled substances, including stimulants and benzodiazepines by members, providers, and pharmacies, and refer them as needed to our Special Investigations Unit (SIU), where specially trained staff assess whether there is evidence of FWA and intervene.

Engaging Members

We understand that members with complex mental health needs requiring higher levels of care (that is, higher than outpatient). Therefore, we employ the following outreach, education, and incentives to assist in appropriate psychotropic medication prescribing:

- [redacted]
- **Text Messages.** Encouraging members on antipsychotic medications to get screened for diabetes.
- **Local Campaigns.** When our BH team receives weekly reports of members who are prescribed an antipsychotic and/or MAT for SUD and do not pick up their medication as prescribed, our dedicated BH Outreach Care Specialist reaches out to these members to assist with any barriers they may have to picking up their medication. We also assess for further needs and refer to a clinician for case management programming if needed.
- **ADHD and Antidepressant New Start Education.** Letters and/or calls to members and caregivers recently starting medications. Education emphasizing importance of follow-up care and taking medications as prescribed.
- **Antidepressant High Touch.** Pharmacist/Technician live telephone outreach to members. Focus areas:
  - Assure the member knows how/why they are taking the medication
  - Provide medication education
  - Identify any medication-related issues
  - Stress the importance of taking medications as prescribed
  - Address any barriers to adherence

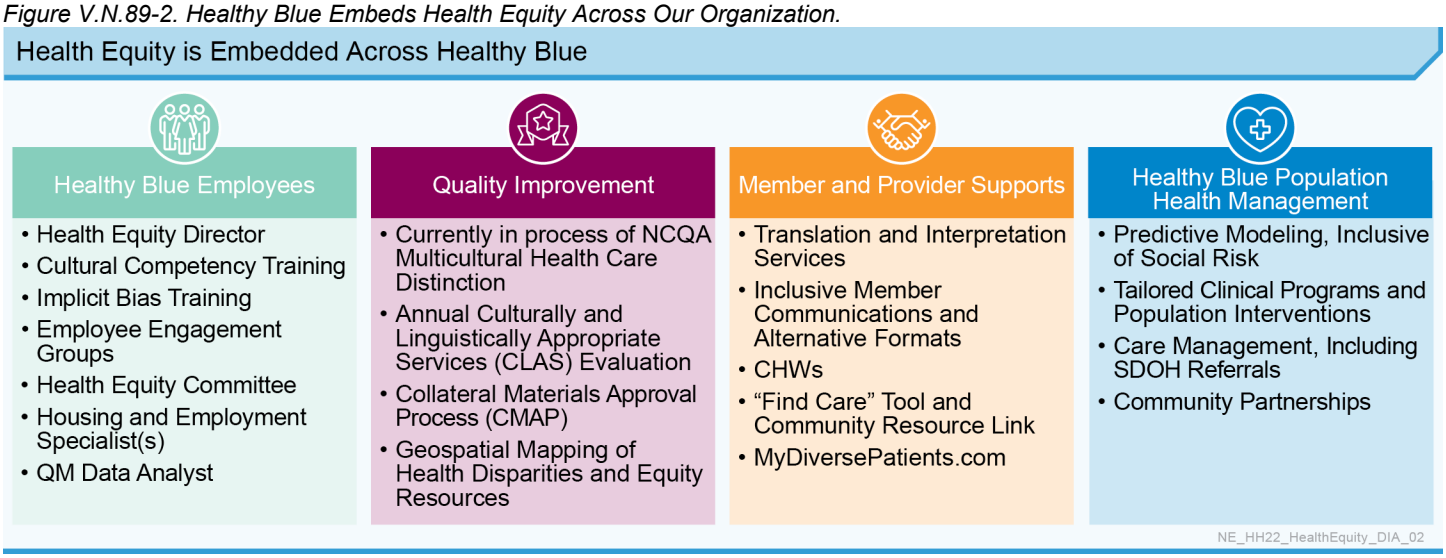
No. 89

Healthy Blue has long recognized that disparities can impact the health outcomes of the members that we serve. Considering all factors that influence health is a key component of ***our Health Equity framework (Figure V.N.89-1)***. By understanding our members' most important needs and connecting them to resources, we can more effectively help them meet their health goals. Health Equity is integrated in all that we do – through our population health approach, provider and community-based partnerships, and Quality Management (QM) activities, we have continuously worked to help identify and address these barriers and continue to develop our understanding and strategies to support our communities' needs.

Figure V.N.89-1. Health Equity Framework.

We continuously evaluate health care disparities using administrative HEDIS, NCQA, and state-required measures, Social Determinant Screeners and health needs assessments, Z-code submissions, and via claims evaluating both race/ethnicity and language stratification. We align our Medical Management strategy to help address these specific health equity concerns on both individual and population health levels. On an individual member level, our Medical Management program uses assessments and myriad information sources to identify SDOH and other barriers to care that contribute to disparities. Our population health and health equity approach identifies geographic, racial, and other factors contributing to inequities in access and outcomes at the ZIP code, county, region, and statewide level. We build from that analysis to understand root causes to further define our medical management interventions, special programs, priority regions and subpopulations, and partnerships. We bring our equity concerns and findings to the Health Equity Committee, led by our ***Health Equity Director, Tiffany White-Welchen, LIMHP*** and comprising our Medical Directors (PH, BH, perinatal), QM Coordinator, Case Management Administrator, Medical Management Coordinator, Dental Director, staff and representatives of diverse backgrounds and cultures who are committed to advancing health equity. We have an exhaustive "no wrong door" approach to collecting data, continuously seeking to expand our capacity to identify and capture this information via Care Managers, Community Health Workers (CHWs), providers, community-based organizations (CBOs), and members via self-lookup on our Community Resource Link. We continue to capture SDOH issues from provider, member and stakeholder feedback through focus groups, advisory bodies, listening sessions, and our Member Advisory Committee. Health Equity is embedded across Healthy Blue as referenced in Figure V.N.89-2. Our local and well-qualified QM team is dedicated to managing and overseeing the evaluation process. Healthy Blue has a ***dedicated QM Data Analyst*** who is responsible for collecting and analyzing data on member and provider outcomes including disparity, SDOH, and care gap data. Healthy Blue also leverages our national Medicaid division's data warehouse to support operational processes, analytics, and reporting.

Figure V.N.89-2. Healthy Blue Embeds Health Equity Across Our Organization.



Methodology and Evaluation

[redacted]

ealthy Blue uses these systems to identify geographic and demographic health disparities and report on opportunities for improvement.

[redacted]

and local levels for our members. With a clear understanding of where care gaps and SDOH barriers are most significant for Members, we focus interventions and community investments and partnerships in areas of greatest need. We conduct tests with pilot populations to measure results in real-time, facilitating prompt understanding of what works and does not work so that we can retool, discontinue, or replace interventions that do not yield positive results and expand those that show quantifiable improvement. Lean and Six Sigma principles also enhance our processes, providing a variety of performance improvement tools, such as cause-and-effect diagrams and control charts, to drive lasting change. With targets in mind, we implement programs to address identified disparities, study the impact of those interventions within stratification groups, then repeat the process using the rapid-cycle Plan-Do-Study-Act method. Once interventions are implemented, we evaluate and determine impact though data collection and analysis (such as evaluating claims for HbA1c screenings or retinal eye exams), provider feedback, incentive utilization, and Care Manager engagement with a focus on our disparity targets. As we identify both successes and opportunities for improvement. This information is aggregated, evaluated, and reported up through our Health Equity Committee and future Dental and current QM Committee for necessary adjustments to improve and sustain our health equity performance.

Health Equity Framework in Action

HEALTH EQUITY

[redacted]

No. 90

Program Integrity

Healthy Blue has built a strong Program Integrity (PI) and compliance approach, combining our five years in Nebraska with our parent company's 30 years of serving Medicaid programs across the country. We take pride in having successfully managed Nebraska Medicaid PI operations from the launch of the program through its evolution to the current program. Over the years, we have worked collaboratively with MLTC to provide feedback and input while remaining agile and flexible in carrying out MLTC policy. We understand that PI is a dynamic endeavor and that constant attention is needed to assure that all direct and indirect stakeholders have confidence the program is not being exploited, misused, or allowing wasteful activity that diverts precious resources from the services our most vulnerable people need. [redacted] We look forward to working with MLTC and other entities in the coming years for the new contract. Healthy Blue meets all requirements as described in Scope of Work (SOW) Section V.O. Program Integrity.
We look forward to working with MLTC and other entities in the coming years for the new contract. Healthy Blue and our contractors and subcontractors meet all requirements as described in the SOW.

Strong PI Organization Oversight and Staff Training

Healthy Blue's comprehensive fraud, waste, and abuse (FWA) and PI efforts rely on highly trained, experienced staff who are empowered by an integrated system of activities, processes, and controls that involve virtually every department. Our PI department is ***locally led*** by our Program Integrity Officer, Jennifer Bohnhoff, who brings more than 16 years of PI experience. Jennifer oversees all activities required by State and federal rules and regulations related to the monitoring and enforcement of the FWA and erroneous payment compliance program, develops and oversees methods to prevent and detect potential FWA and erroneous payments, reviews records and refers suspected member FWA to MLTC and other duly authorized enforcement agencies, and manages the Special Investigations Unit (SIU) to communicate with the State's Medicaid Fraud Unit. She has been the primary point of contact for MLTC PI since 2018. Our PI organization is comprised of multiple teams across the organization, working together to assure appropriate payments for MCO covered services provided to eligible Medicaid members. These diverse teams implement and participate in our overall strategy and work in concert to execute Healthy Blue's PI plan:

- ***Our Claims Payment Integrity (CPI) team*** is responsible for two major areas: coordination of benefits (COB) and data mining. COB functions include identifying and validating other coverage and identifying recovery and prevention savings. Data-mining functions (pre- and post-payment) include applying claim overpayment and algorithms to assure compliance and detect potential FWA.
- ***The COB team*** develops and maintains reimbursement policies and is responsible for code editing (administrative and clinical edits, correct coding, and customized FWA edits) and medical edits that apply industry-standard logic to claims coding (inappropriate code-to-code relationships).
- ***The Subrogation team*** recovers expenses when another party is liable for an accident or injury claim.
- ***The SIU*** investigates known or suspected fraudulent or abusive activities by providers and members and increases awareness of methods to detect, correct, and prevent FWA, collaborating with regulatory agencies and law enforcement to mitigate fraud and abuse. To support the Heritage Health program and in accordance with RFP requirements, the SIU staff will include one staff person for every 50,000 members. Our investigative team is located throughout the state, enabling easy and efficient provider on-site visits.

Employee Training in Compliance Plan and Fraud, Waste, and Abuse

Healthy Blue presents an annual training to all our leadership and employees regarding identifying and reporting suspected FWA, health plan benefit packages, and Nebraska laws and requirements governing Medicaid reimbursement and the utilization of services. We educate employees on the Nebraska Administrative Code and the Nebraska False Claims Act. Trainings emphasize changes in federal and State laws and rules governing Medicaid, provider participation, and payment as directed by Centers for Medicaid and Medicare Services and MLTC. We understand and comply with all FWA education requirements as defined in SOW Section V.O.6 Program Integrity Employee Education About FWA.

In addition, we require all new employees to complete FWA training within 30 days of beginning employment and at least annually thereafter. We track completion of required trainings and escalate to management any employee who has not completed by the deadline. We deliver our modular FWA course through our web-based learning platform as part of the overall compliance training that meets federal, State, and local requirements. The course includes topics and knowledge checks such as:

- Information security and reporting security concerns
- Employee misconduct and how to report it
- Medicaid/Medicare compliance
- Duplicate billing
- Provider and member FWA and how to report it
- Member safety
- False Claims Act/whistleblower protections
- Medical coding: miscoding, upcoding, unbundling, and overutilization
- Services not rendered

We update the training curriculum periodically to reflect changes in rules, regulations, policies, and laws regarding FWA. We provide department-specific training to employees in operational departments such as Claims, Utilization Management, and Quality Assurance. The training sessions encourage employees to remain vigilant in identifying FWA indicators and inform employees on how to report concerns regarding provider or member fraud to the SIU.

Compliance Plan

Our Compliance Plan, a document developed by our Compliance department, is based on the Code of Federal Regulation's seven elements of an effective compliance program and serves as a core resource to Healthy Blue in preventing, detecting, reporting, and implementing corrective actions for suspected cases of FWA and erroneous payments. Our Compliance team works with plan leadership to develop a comprehensive Compliance Plan that covers:

- Procedures for ongoing monitoring and auditing of our systems
- Provisions for the confidential reporting of plan violations
- Non-retaliation policies
- Provisions for prompt responses to detected offenses and corrective action initiatives

- Annual submission (and prior to any material change) of FWA policies and procedures, the Compliance Plan, and names of Compliance Officer and Program Integrity Officer

Our Contract Compliance Officer, Christine Cole, along with Jennifer Bohnhoff, reviews the Compliance Plan with final approval by our CEO, Robert Rhodes. We submit this plan to the State annually and update it at least quarterly to incorporate new program policies or requirements and to reflect emerging issues or evolving best practices. We next describe our approach to addressing each required Compliance Plan component.

Healthy Blue's Approach to Fraud, Waste, and Abuse Prevention and Detection

We ***prioritize prevention to be less disruptive to our provider community***. As part of our FWA program resources, we employ a comprehensive, sophisticated, and flexible set of more than 1,000 data analytic algorithms for fraud prevention (proactive) and detection (reactive).

Controls for Preventing and Detecting Fraud and Abuse

Our claims processing system — from intake through payment — includes controls that prevent and detect potential or suspected FWA for all claims submitted. Our claims system assigns each claim a unique internal control number to track progress from initial entry to final adjudication. At onset of the adjudication process, the claim goes through our prepayment review (PPR) system, which is highlighted through regular edits as well as specific FWA tools and analytics. Our automated prepayment claims-editing tools perform audits on submitted claims and apply correct coding edits. Our SIU prepay process assures medical record review on identified providers before payments are ever processed. We then use internal data analytics reports to identify outlier provider activity. While PPR and reports occur, surveillance and/or utilization management protocols safeguard against unnecessary or inappropriate use of Medicaid services. When data mining for potential FWA, we reference the Nebraska Administrative Code, Heritage Health provider handbooks and modules, Medicaid banners and bulletins, and benefit coverage limitations.

Continuing through the claims lifecycle, Healthy Blue performs desk audits on post-processing claims review. Our review includes claims evaluation for upcoding, unbundling, inappropriate use of modifiers, and billing for services not performed. The SIU and its Special Workgroup Analytics Team (SWAT) use the STARSInformant rules-based fraud detection tool and report findings through our proprietary data-mining tools, as well as Medicaid schemes and trends across all lines of business. All credible allegations of member fraud or abuse are immediately referred to the Attorney General's Office. Our Healthy Blue Medicaid provider handbook and provider agreement detail credentialing standards. We perform ongoing monitoring to verify continued compliance with our standards and look for any action that may reflect substandard conduct and competence. We review periodic reports when available through sources such as the Office of Inspector General (OIG), federal Medicare or Medicaid reports, Office of Personnel Management, licensing agencies, and our Quality Management department.

During post-payment review, we include medical records review and supporting documentation for accuracy, appropriateness of codes billed, standard documentation rules, and education to our providers when we identify abnormal billing outliers. Through our education efforts, we track providers' change of behaviors. Healthy Blue also develops new post-payment, rules-based queries through data-mining operations that search everything driving overpayment capture — from duplicate payments to retroactive rate changes.

Our controls consist of more than pre- and post-payment reviews. We also review reports for provider profiling and credentialing aid program and PI, including:

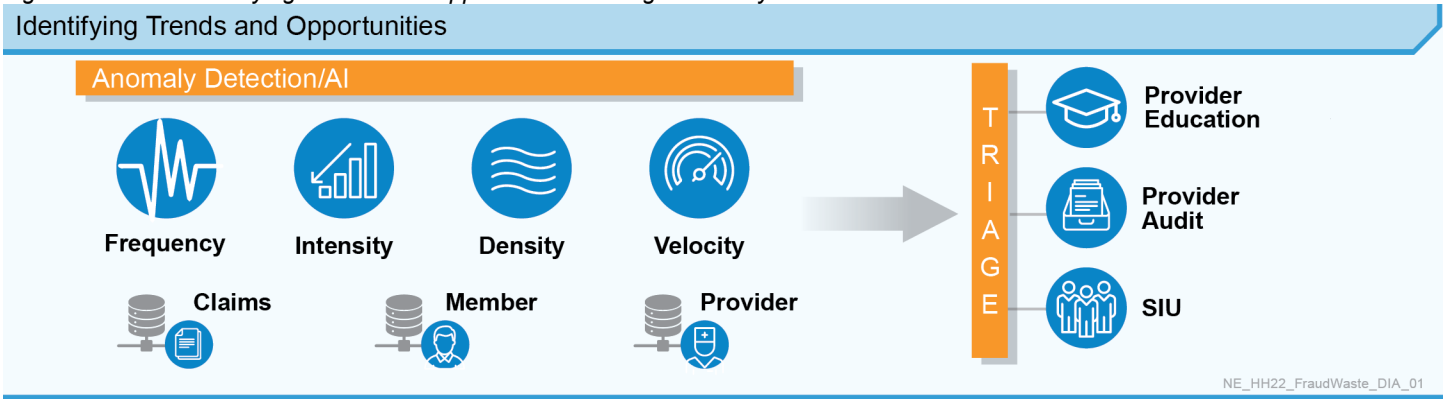
- State Licensure Verification and related sanctions
- National Plan and Provider Enumeration System (NPPES)
- OIG List of Excluded Individuals/Entities, System for Award Management, and Nebraska Disciplinary Actions Against Health Care Professionals and Child Care Providers List
- U.S. Department of Treasury Sanctions List Search Tool
- Bridger Insight (LexisNexis)
- Social Security Death Master File
- Drug Enforcement Agency
- Controlled Dangerous Substances and State-controlled substance certificates
- Malpractice insurance and malpractice claims histories
- Work histories

Anomaly Detection AI is a suite of advanced proprietary models that predict and flag suspicious trends in provider billing patterns. Through peer comparison and historical trend analysis, these models identify atypical behavior patterns using analytic data algorithms that analyze risk populations (provider, member, procedure, and diagnosis) against risk dimensions. Provider profiling, performed annually at a minimum, incorporates comprehensive review of the provider's billing history to identify aberrant service and billing patterns warranting further review or audit. Profiling through use of encounter data compares individual providers to providers of the same peer group, while considering the individual provider's case mixture to identify. For example:

- Non-emergent transportation trips with no matching medical claim
- Provider use of high-level codes versus lower-level codes as compared to peers
- Month-over-month payments to provider, reviewing for unexpected or unusual spikes
- Monthly review of billing patterns for providers who are new to the network

We use benchmarking metrics to support our pre- and post-payment programs. Monthly analysis using our claims activity dashboard supports the generation and verification of leads related to potential provider FWA. This dashboard displays a rolling 13 months of data and supports sorting, filtering, and drill-down analysis on several elements, including county or city, provider TIN, and top procedure codes. The ability to show a summary of billing history for a provider, including a change from last month and peer comparison, is a key strategy to detect and prevent provider FWA. Provider profiling also includes a review of the OIG LEIE, the federal LEIE, SAM Excluded Parties List, license verification, and billing history to check for fraud. Our proactive approach using Anomaly Detection AI is shown in Figure V.O.90-1.

Figure V.O.90-1. Identifying Trends and Opportunities Through Anomaly Detection.



Reporting Fraud, Waste, and Abuse

We make PI and Compliance everyone's job. Healthy Blue staff all have an obligation to report to any suspected provider or member FWA to the SIU. Reporting suspected FWA is a condition of our employment. We all are committed to "do the right thing." The SIU provides our staff with various channels to submit reports or to ask questions. ***Our organization's website https://www.fighthealthcarefraud.com won the 2020 National Health Care Anti-fraud Association® (NHCAA) award*** for the comprehensive information it provides on red flags and actions available when a person suspects FWA. Amerigroup employees can contact the SIU and report confidentially and anonymously by:

- Calling the fraud hotline
- Submitting using the intranet web form (internal access only)
- Submitting using the internet web form
- Calling the Member Services Call Center

Healthy Blue has a policy of non-intimidation and non-retaliation for good faith PI participation, including reporting and investigating potential issues; conducting self-evaluations, audits, and remedial actions; and reporting to appropriate officials. Any employee, regardless of seniority or status, who engages in or condones retaliatory activity is subject to corrective action, up to and including termination. All employees receive a refresher training each year on whistleblower protections and our non-retaliation policy.

We will continue to promptly report preliminary investigation results and suspected and confirmed cases of FWA to Nebraska PI and Medicaid Fraud Control Unit (MFCU). We have an excellent record of meeting Nebraska PI and federal requirements for report timeliness and quality and will continue to do so under the new contract. We execute quality reviews on all reports before submission, generating reports in advance of Nebraska PI deadlines to allow adequate time for thorough reviews. These reports identify:

- Monthly tips reports on all preliminary investigations opened during the reporting period
- Quarterly reporting on all audit and investigation activities, including provider education, PPR metrics, and identified waste and error overpayments and collections across the calendar year
- Quarterly financial reporting for tracking recoveries

We will promptly implement any new reporting requirements upon request.

Implementation of Corrective Action

Our SIU assesses and prioritizes referrals and initiates investigations within seven business days of receipt. If the preliminary investigation supports a finding of suspected fraud or abuse, Healthy Blue will submit a referral form to Nebraska PI as soon as possible and no later than two business days after the finding. Healthy Blue will take no further action until we hear from the State. If the referral is declined, we will proceed with our own investigation. If it is accepted, we will take whatever further action we are instructed to take. We will continue to participate in our quarterly training meeting with MLTC Program Integrity, including continuing to facilitate training on emerging trends and the innovative ways that we have addressed them.

Best Practices From Other States

Our parent company has national experience that allows Healthy Blue to identify emerging trends — but our local knowledge enhances our insight on how our parent company's best practices best relate to Nebraska. ***We leverage PI tools across our affiliates in 26 market as well as other lines of business, including Medicare and commercial plans, which allows us to stay current with national trends and findings that we then bring to a local level in Nebraska.*** Our ***Anomaly Detection AI tool*** allows us to identify atypical behavior patterns through peer comparison and historical trend analysis across our affiliates in 25 other markets. For example, we saw data across multiple affiliates that showed overutilized billing codes for individual psychotherapy sessions based on face-to-face time spent in session. Based on this trend, we then analyzed our local claims data in Nebraska and discovered a multi-specialty group using those same billing codes in excess. As a result of this review, we further identified a lack of documentation to support billing under these codes, as well as missing patient consent forms and individualized treatment plans. We then referred the case to the Department of Health and Human Services, and the case remains under review. We remain committed to being good stewards of public funds and collaborating with MLTC and the MFCU to support Nebraska PI goals and objectives and look forward to partnering with MLTC and MFCU in the new contract.

No. 91

Working with Entities to Investigate and Prosecute Fraud, Waste, and Abuse

As an incumbent serving Nebraska Heritage Health members, Healthy Blue has built strong relationships and established robust processes as part of our experience in Nebraska. Our local approach to addressing fraud, waste, and abuse (FWA) is supported by more than three decades of organizational experience serving Medicaid programs across the country. This support from our parent company provides extensive insight into billing patterns, utilization, trends, and focus areas on the Nebraska health care delivery system, including tele-fraud, durable medical equipment, lab schemes, and prescription drug fraud. Our FWA process and procedures and Program Integrity program comply with all requirements outlined in Section O, Program Integrity, of the request for proposal (RFP).

We remain committed to being good stewards of public funds and have a strong track record of collaborating with the Nebraska Medicaid Program Integrity Unit (NMPIU), Medicaid Fraud Control Unit (MFCU), and Nebraska's Medicaid Fraud and Patient Abuse Unit (MFPAU) within the Nebraska Attorney General's Office to support the detection of FWA. We prioritize the identification, investigation, and correction of FWA, recognizing that ***fraud is everyone's concern***.

Our Special Investigations Unit

Our Special Investigations Unit (SIU) brings nearly 100 years of combined experience to their roles. This team, which includes Investigators, Clinical Coders, Program Integrity (PI) Managers, and our Reporting team, is supported by more than 20 shared services employees and maintains strong relationships with State entities. The SIU is a critical part of our PI strategy. To support the Heritage Health program and in accordance with RFP requirements detailed in Section O, Program Integrity, our staff will include, at a minimum, one Nebraska-based staff person for every 50,000 members and our local PI Officer. Our investigative team is located throughout the state, which enables easy and efficient on-site provider visits.

Our SIU reviews leads, identifies cases, and conducts investigations. All substantiated findings of potential FWA are then referred to the NMPIU to determine if they will pursue the matter further or return to us to recover overpayments. The SIU focuses on issue-driven concepts to identify multiple providers engaged in similar billing schemes across our affiliates. In addition, national "watch lists" identify common nationwide schemes as well as aberrations not yet seen in certain states. Advanced data analytics evaluate paid claims across affiliates to identify local aberrations and national fraud trends.

In addition to our dedicated Nebraska SIU team, Healthy Blue can draw from the extensive resources and expertise of our parent companies' national SIU teams, which consist of Investigators, Prepay Reviewers, Clinical Fraud Investigators, and support staff. Capabilities and experience among SIU employees are varied and diverse, which means we can leverage experience across all states and lines of business. ***Our SIU team maintains a close relationship with industry organizations focused on health care fraud and abuse prevention. For example, one of our SIU Investigators, Troy Bailey, previously worked at DHHS and maintains strong ties to his former employer as well as the MFCU.***

To expand our reach, we hold quarterly meetings between our PI staff and peers at Blue Cross Blue Shield Nebraska (BCBSNE) who lead FWA efforts related to commercial and Medicare plans. At these meetings, Healthy Blue and BCBSNE share information on fraud schemes and concepts, investigative techniques, providers under investigation, best practices, and lessons learned. ***The ability to gain insight from BCBSNE, an insurer serving more than 600,000 members across Medicare and commercial lines of business, expands our capacity to prevent and detect fraud.*** This collaboration not only generates leads or cases — it also informs and enhances our analytics having a more robust data set for the entire Nebraska Medicaid program.

The SIU participates in Compliance Committee meetings, chaired by Healthy Blue's Compliance Director, to discuss high-level SIU metrics. The SIU hosts monthly meetings for health plan leadership from additional functional areas that allow the SIU team to deep-dive into open cases, new trends, and schemes, and to provide detailed updates regarding provider responsiveness to audit activities. The SIU team uses this meeting to provide the best possible service to our providers and reduce abrasion while conducting necessary oversight and corrective actions.

How Our SIU Collaborates with Other Entities. Our SIU has built a reputation in Nebraska for our transparency and seamless cooperation with federal and State entities. We understand the importance of adapting our FWA program to evolving risks and monitoring new fraud schemes identified by various organizations. Our strong partnerships with Nebraska regulatory agencies and law enforcement includes participating in: Regional task forces aimed at reducing health care fraud, including FBI-sponsored task forces in many states. Through these relationships, we share information and best practices in avoiding and detecting FWA, allowing us to continuously enhance our program.

- CMS-sponsored FWA outreach and education events to provide us with information on current trends and tools in health care fraud prevention
- An early relationship with the Healthcare Fraud Prevention Partnership that provides a way to share data and information between public and private sectors to detect and prevent health care fraud
- Quarterly meetings with MFPAU and NMPIU to discuss active investigations

Examples of Applying Our Program Integrity Methods in Nebraska

We pride ourselves on our commitment and transparency in working with the State and other entities. Our local SIU team has fostered strong partnerships with DHHS and other entities while Healthy Blue has been serving Nebraska over the past five years. The following recent examples, show our SIU team's proactive and thorough approach to fraud detection in Nebraska and our collaboration with federal and State agencies:

Improper Billing Codes from a Multispecialty Group. [redacted]

[redacted]

No. 92

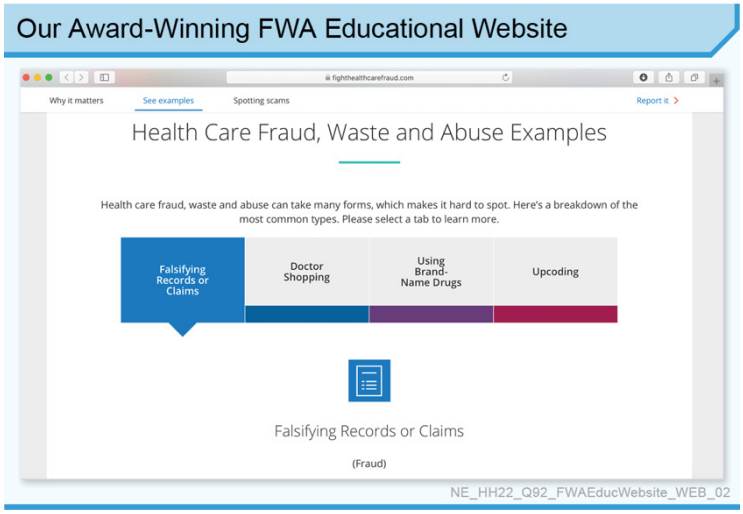
Education for Members and Providers on Preventing Fraud, Waste, and Abuse, and Erroneous Payments

We understand that prevention of fraud, waste, and abuse (FWA) begins with education, and we aim to engage our members and providers with clear information on FWA prevention that empowers them to collaborate with us in spotting and reporting suspicious activity. Healthy Blue complies with all federal and RFP requirements to educate employees, subcontractors, members, and providers about our compliance plan, FWA prevention, erroneous payments, and how to report any allegations of them. As an incumbent, all of the strategies detailed in this section have been implemented and applied effectively in Nebraska. [redacted]

Education for Members on Fraud, Waste, and Abuse Prevention

We use multiple methods to engage and educate members on FWA prevention. We rely on collaboration of all stakeholders to have the most meaningful impact. Upon enrollment, we provide a welcome packet with a welcome flier; ID card that includes telephone number to report FWA; and member website, which highlights ***our award-winning www.fighthealthcarefraud.com website***. Figure V.O.92-1 shows a page from this website that provides clear examples of FWA and disseminates information in an easy-to-understand way that fosters a culture of vigilance for spotting and reporting FWA.

Figure V.O.92-1. A Page from Our Award-winning FWA Website.



We also share educational videos on our dedicated FWA web page. Members can report FWA by calling the toll-free Member Services Call Center number listed on their ID card, the website, and member handbook. Members may also view their claims in the member portal and detect potential FWA. Additionally, we address FWA as a semi-annual topic at Member Advisory Committee meetings.

Fraud, Waste, and Abuse Training for Network Providers and Subcontractors

Through Healthy Blue's ***Medicaid Training Academy***, we offer providers and subcontractors initial and ongoing FWA training sessions several times per year. Our Nebraska-based Provider Experience team often delivers in-person or virtual provider training, with information tailored to address Nebraska-specific benefits for all provider types. Providers receive initial training within 30 days of joining our network. We offer training via individual, group, and on-demand/online resources and through direct outreach by Healthy Blue staff.

Education includes definitions and examples of FWA, reporting and investigation procedures, possible actions and outcomes, prevention (member verification, proper documentation, and bill accurately), and where to find more information.

Our SIU Vendor Liaison, Brenda Teplitsky, is an educational resource and designated point of contact for subcontractors regarding FWA. In concert with our SIU Manager, Brenda conducts an annual FWA roundtable with delegated vendor subcontractors. During this roundtable, the group shares examples of identification, investigation, and resolution of FWA cases and exchanges information with Healthy Blue about potentially fraudulent activity. We conduct education campaigns throughout the year based on trends we are seeing related to FWA. In 2021, this included campaigns specifically focused on:

- Risk of documentation cloning
- Requirements for high-level vision/medical evaluation and management services, which results in double-billing
- Trips to Nowhere for Non-Emergency Medical Transportation (NEMT) services, where medical claims do not support rides
- Telehealth schemes for both vision and dental
- Overutilization of injection codes (for vision)
- Misrepresentation of services (NEMT, dental, and vision)
- Work to educate providers on incorrect billing practices to help drive change in behavior before it becomes fraud
- Providers are educated on how to find information on the provider website when they join our network and there is overpayment language in our provider contracts that providers must agree to when they sign our contract. They are also informed that our Provider Services staff are available to assist providers in overpayment reporting.

Our Member and Provider Services Representatives receive training in FWA and are prepared to assist providers with any questions they may have. Our provider materials, including the provider handbook, outline our FWA program and provide detailed reporting instructions. Our provider website also offers information about reporting FWA. Provisions for the confidential reporting of suspected FWA or PI Plan violations include:

- **Hotline.** A voice-mail box enables callers to leave information on a confidential hotline. We encourage confidential reporting of FWA allegations via toll-free number.
- **Online.** FWA reporting links on our website.

For providers and subcontractors, we offer FWA information through multiple channels, including monthly newsletters; provider orientation and bulletins; and well-publicized reporting channels, such as our Compliance Hotline and Healthy Blue member and provider websites, which link directly to our award-winning website www.fighthealthcarefraud.com.

Mitigation Strategies for Erroneous Payments

Healthy Blue requires that all its providers, contractors, and subcontractors take all the necessary actions to permit us to comply with FWA and erroneous payment requirements included in this contract and state and federal regulations. We give providers, contractors, and subcontractors ample education on how to self-disclose erroneous payments and return those payments after approval by National Medicaid Pooling Initiative (NMPI). Information on how to do this is included in our provider contracts, our provider website, and in initial and ongoing trainings on how to self-disclose erroneous payments and return those payments after approval by NMPI.

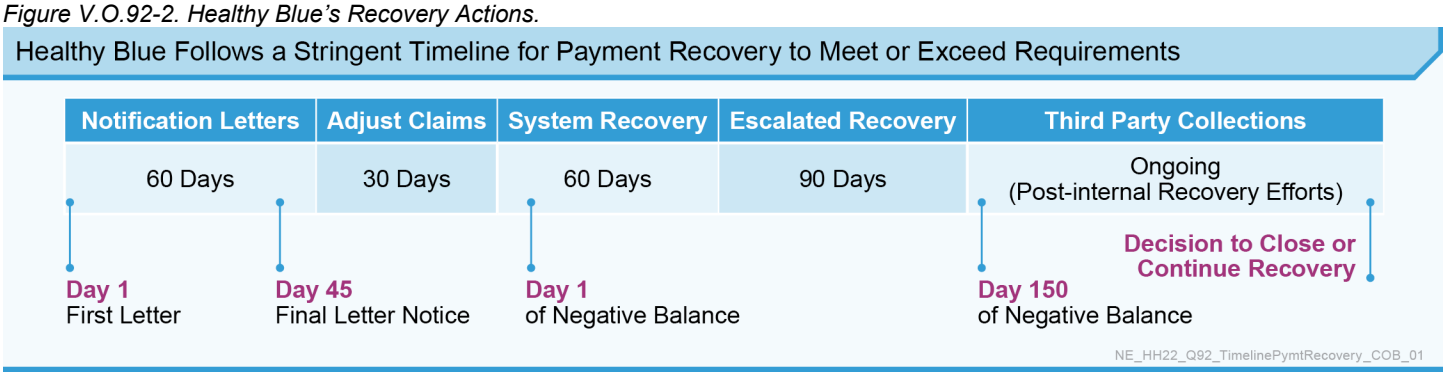
Our FWA and erroneous payment unit oversees our erroneous payment process and manages provider recoveries through tracking databases, regular reporting, and a structured recovery process. We follow all requirements in the recovery process for overpayments as defined in the SOW Section O.

Pre- and post-payment processes enable us to identify provider overpayments through CPI analytics, including: Third Party Liability and COB for pay-and-chase situations and post-payment identification; data mining that analyzes claims against payment, reimbursement, and benefit policies; retroactive eligibility changes; and claims quality audits performed on a random sample of Nebraska claims.

Healthy Blue has procedures in place for the treatment of recoveries for identified overpayments. Figure V.O.92-2 shows our timeline for actions related to payment recoveries from notification letters to third party collections. We assure State and federal regulations are reviewed to assure the timing of refund requests and notification requirements are valid. When no specific regulation applies, Healthy Blue will:

- Notify a provider in writing of the requested overpayment.
- Wait a minimum of 45 days for the provider to respond to the written request.
- When a check for the requested overpayment is not received, perform offsets to future claims.

Figure V.O.92-2. Healthy Blue's Recovery Actions.



At Healthy Blue, we emphasize prevention to stop FWA and erroneous payments before they occur. We have built this approach to prevention and education on our five years serving Nebraska and look forward to continuing to serve Nebraska Medicaid and members in the new contract.

No. 93

Third-party Liability and Payment Information

Healthy Blue is committed to responsible and fair processes that ensure that members receive the care and services they need without resulting in unnecessary and inappropriate costs to the Medicaid program. Our third-party liability (TPL) activities are seamless, flowing through claims, our Member Services Call Center and provider toll-free telephone line, and other staff who may interact with members who have other health insurance (OHI). Healthy Blue maintains sound fiscal management by engaging cost containment experts responsible for a wide variety of programs, including identification of OHI, cost avoidance through coordination of benefits (COB), overpayment/collections, and subrogation. We leverage experienced financial personnel, technology, automated applications, and consistent, replicable processes. Healthy Blue and all of our providers, contractors, and subcontractors understand and comply with the TPL requirements as defined in SOW Section V.S.

Capturing and Identifying TPL and Payment Information

We designed our cost avoidance efforts so that Medicaid is the payer of last resort. We do and will continue to make every reasonable effort to determine the liability of third parties to pay for services to members, including through automated and manual verification processes. Healthy Blue employs a number of cost avoidance strategies, including capturing OHI data from all available sources (including DHHS), validating OHI information received, storing the information on a member's electronic record, and applying it appropriately when processing each claim. Healthy Blue strives to maximize the identification of OHI and TPL and increase cost avoidance by:

- Capturing any available data regarding OHI, including receipt and processing of an electronic file from DHHS
- Dedicating staff to the daily review and update of potential OHI and TPL leads received from members and providers
- Validating potential OHI leads with the primary carrier; information is stored in the member's electronic record
- Reporting to DHHS members identified as having Medicare coverage
- Incorporating a series of edits into our claims processing system to identify alternate insurance information
- Suspending claims where OHI data is attached to the member record and triggering them for follow-up
- Automatically incorporating COB information into the claims adjudication process
- Evaluating root cause analysis and educating providers to reduce billing errors

We work to identify OHI coverage and TPL prior to claims payment to minimize the need for more difficult and costly post-payment recoveries and underpayment adjustments. Quality is the driving force for our TPL activities, and we have extensive processes in place that facilitate review and improvement. Throughout members' relationship with Healthy Blue, we identify OHI they have using a number of methods:

- **DHHS Files.** Loading third-party resource information from DHHS into our maintenance Medicaid Management Information System (MMIS) within one business day of receipt (significantly outperforming the 30-day requirement)
- **Claims Information.** Capturing member third-party coverage when the provider submits a claim that lists third-party resources or indicates payment from another insurer
- **External Partners.** Enhancing internal identification activities with external partners to identify and verify member third-party resource information
- **Member Interactions.** Asking members about other insurance coverage during routine communication, especially by Care Managers

Cost containment validates internally generated leads, including those from provider-submitted claims and member contact. Employees conduct a daily review of all potential TPL leads and validate information with the primary carrier. We add validated third-party coverage information to the member's record in our MMIS within 24 hours of verification, including the policy issuer and number, policy holder, effective and termination dates, and last date verified. For members with other coverage, COB is automatically incorporated into the claim adjudication process.

Healthy Blue's TPL processes align with and reflect the varied catalysts of third-party liability. We recognize that a case-by-case analysis may be necessary, particularly with trauma and accident cases where the liable party may initially be undetermined. In compliance with the SOW requirements, we seek reimbursement in accident/trauma-related cases when claims in aggregate equal or exceed $250 for a member in a contract year.

Where a third-party resource is identified prior to payment, we follow appropriate COB standards. Otherwise, will follow a pay-and-chase policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Healthy Blue handles the filing of liens and settlement negotiations both internally and externally via its vendors.

Adjudicating Claims Involving Third-party Coverage

After Healthy Blue identifies potential TPL, we deny the claim when there is a liable third party. Our claims systems and procedures evaluate the type of TPL coverage against the service on the claim. Our claims processing system is fully integrated with our TPL process to:

- Capture third-party coverage information contained on the claim
- Evaluate third-party coverage information stored on the member's electronic record
- Suspend claims where TPL is indicated, unless the service is designated as a cost avoidance exception (pay-and-chase) in accordance with 42 CFR 433.139

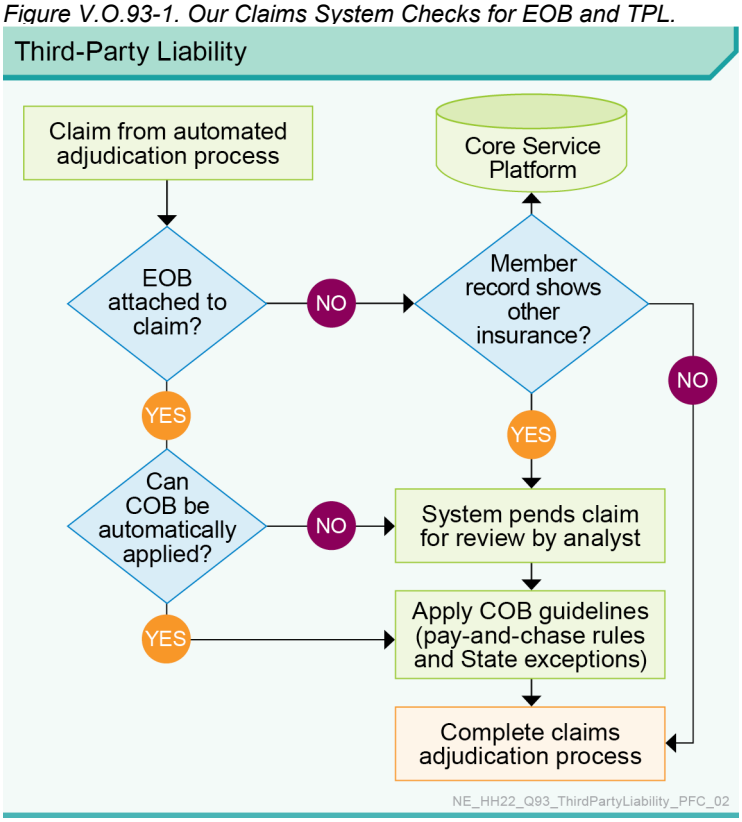
Our claims system applies a series of edits to identify and prevent potential overpayments based on the member's other insurance information or indication of prior adjudication by the primary carrier. Through these edits and associated processes, we will make sure that known TPL is billed prior to paying a claim.

In compliance with SOW requirements, if a TPL insurer requires the member to pay any copayments, coinsurance, or deductibles, we assume responsibility for making these payments even if the services are provided outside of our network.

As shown in Figure V.O.93-1, our system checks the claim for the presence of an Explanation of Benefit (EOB) (indicating prior adjudication) and any third-party resources documented on the member's record. If an EOB is attached, indicating primary carrier adjudication, COB is performed automatically or the claim pends for review. An analyst reviews pended claims and attached EOB(s) to make sure that any copayment, coinsurance, or deductible amount required by the primary carrier is considered in determining any balance due to the provider and that the combined payments do not exceed allowable amounts. If the claim does not reflect primary carrier adjudication or references payment and no EOB is attached, we deny the claims and return it to the submitting provider with information on the other carrier, including address, policy number, effective date, and policy holder. We include instructions to bill the appropriate third party for payment and then resubmit a claim if there is a balance owed.

If no EOB is attached, the system checks for third party resources in the member's record. If present and the claim dates of service are within the effective and termination dates of the other coverage, the claim pends for analyst review. If the claim is covered by pay-and-chase rules or State exceptions, it is paid and subject to retrospective recovery. If exceptions do not apply, the claim is returned to the provider with instructions to bill the appropriate third party.

Figure V.O.93-1. Our Claims System Checks for EOB and TPL.



Provider Education

Healthy Blue has established continuing education and other similar programs for providers. In addition to our provider handbook, Healthy Blue provides easy-to-read yet detailed written billing instructions for providers in its ***claims and billing manual***, including the following topics:

- Statements in plain language about claims where third-party payment may affect the reimbursement amount established for services, which helps providers make stable financial planning decisions
- A simple chart showing a coding system that allows providers to routinely flag known conditions surrounding a patient's treatment that may financially implicate a third party, such as auto accidents, employment-related injuries, or suspected tortious liability
- Descriptions of standardized fields for recording OHI information, whether public or private, and detailed instructions for correcting claims to adjust OHI information
- Requirements for paper claims
- Instructions on submitting claims with the proper HIPAA-compliant code set, which we provide for direct download into the provider's practice management software upon request
- Explicit information that providers may not engage in balance-billing of members who are dually eligible for Medicare and Medicaid

Providers can find the most recent version of the manual, as well as more information about requirements, benefits, and services, on our provider website. We also welcome provider questions and recommendations for improvement through our Provider Services Call Center.

Leveraging TPL Information — Recovery and Distribution

Our cost avoidance and recovery strategies prudently manage Medicaid funds while minimizing impact on members and providers. While we will actively pursue legal avenues to recoup Medicaid monies, we carefully evaluate all cost avoidance strategies to ensure that they do not prevent members from receiving medically necessary services.

Retrospective Post-payment Recovery Activities. Once we adjudicate claims and disburse payments, we will analyze data to retrospectively identify recovery opportunities, including pay-and-chase situations and subrogation. We seek recovery within 60 calendar days after the end of the month we learn of the existence of a liable third party after a claim is paid. We understand and comply with all SOW requirements for recovering and distributing TPL, including pursuing reimbursement from a client if they receive the third-party resource or settlement directly.Post-payment recovery activities combine resources from cost containment with an external recovery partner to maximize collections. Our partner will compare processed claims information against their data repository from more than 150 health insurance organizations, identify the liable third party, and bill it for payment. Whenever overpayments are identified, the recovery process will include the following steps:

- Gather all claims documentation
- Send written notification to the provider of the overpayment, with supporting documentation
- Offer providers the option of refunding the overpayment or offsetting future payments
- Wait a minimum of 45 days for the provider to respond to the written request
- After confirmation, adjust the individual claim record and configure the provider's record to either accept a refund or withhold future payments up to the overpayment amount

Our parent company's wholly owned subsidiary and our affiliate, Meridian Resource Company, LLC (Meridian), manages our subrogation activities. Our affiliate sets up investigations into subrogation-related TPL based on trauma-related diagnosis codes, data mining, file identification through property and casualty claims databases, attorney letter inquires, and other sources of subrogation leads. After a subrogation examiner completes an investigation into a subrogation-related TPL lead, our affiliate's subrogation analysts

will monitor the status on a subrogation claim to its ultimate negotiated resolution and payment. [redacted]

Healthy Blue will note all recoveries in the claims record for reporting to DHHS through encounter records. When we identify new third-party coverage information through the recovery process, we will incorporate it into the member record to facilitate COB for future claims.

Distribution of TPL Recoveries

Healthy Blue complies with MLTC's requirements for third-party data and files and distribution of TPL recoveries. We understand that we may retain up to 100% of our TPL collections if the following conditions exist:

- Total collections received do not exceed the total amount of Healthy Blue's financial liability for the member per claim or tort case
- Collections do not include payments made by MLTC related to fee-for-service claims, reinsurance, or administrative costs (for example, lien filing)
- Such recovery is not prohibited by applicable law

Our policies and procedures reflect these requirements and we continue to hold ourselves to be transparent, cooperative stewards of State Medicaid funds in the identification and pursuit of TPL.

No. 94

Approach to Implementing Value-based Purchasing Models with Providers

We are a leader in developing value-based purchasing (VBP) programs to link provider payments to measures of quality and efficiency. ***We take a broad-based approach — including as many providers as possible to expand the reach of VBP programs and advancing the goal of transformational population health management.*** We fundamentally understand — absent accountability for cost, utilization, and appropriate care — fee-for-service (FFS) payments are incompatible with patient-centered care delivery. To that end, our VBP programs incentivize providers to move away from FFS reimbursement and toward methodologies rewarding them for the quality of care they provide, measured by improved member health outcomes and reduced health care cost.

Value-based Purchasing and Risk-sharing Agreement Philosophy

VBP arrangements reduce inappropriate care and improve population health and health equity. Together with our affiliates, we have extensive experience designing and advancing VBP programs that align with specific State goals and meet the unique Nebraska population health needs. We demonstrate our commitment to transforming care delivery by supporting the transition away from traditional FFS payments. [redacted] We are leveraging the success and experience of our parent company and working closely with Nebraska stakeholders to implement our VBP programs.

Our VBP strategy is built on the Quadruple Aim principles of:

1. **Improving Member Experience of Care.** By tying incentive payments to improved quality performance, our VBP programs incentivize improved patient engagement and effective care coordination. Our programs also promote collaboration with our care coordination system, which encompasses utilization management, disease, discharge planning, continuity of care, care transition, and quality management.
2. **Improving Provider Experience.** We engage with Nebraska providers by conducting listening sessions to assess how VBP program design and supports can be used to drive greater engagement and results. We reduce provider administrative burden by offering consistent, easy-to-use data and reporting tools for our VBP programs. Our provider portal combines a digital platform and health applications designed to continuously improve outcomes and yield cost of care improvements. The provider portal can reduce the administrative cost for providers by eliminating manual record exchanges, reducing chart chasing, and streamlining fulfillment of compliance and audit requirements.
3. **Improving the Health of Populations.** VBP is a key component to improve population health, and we align our programs with population health goals and social determinants of health (SDOH) and quality outcome measures. To truly improve health and health equity for Nebraskans, we know that our programs must address member physical and preventive health, behavioral health (BH), and social needs such as housing, education, and food security. With this in mind, we have selected to promote these areas (for example, BH and substance use disorder (SUD) measures for follow-up after hospitalization for alcohol or drug dependence).
4. **Reducing the Per-capita Cost of Health Care.** We align incentives with benchmarks for quality performance against national standards and outcomes with the goal of reducing the overall cost of care by providing care in the most appropriate setting. Our organization has been a leader in Nebraska and nationally in the design and implementation of transformational VBP programs in conjunction with our provider partners. We have cultivated strong relationships in Nebraska, where we make extensive use of VBP programs, including a prospective per member per month (PMPM) payment to support practice transformation, and member engagement activities.

We align our VBP program measures and targets to advance the Nebraska DHHS Quality Strategy for Heritage Health and the Dental Benefit program and the MLTC goals of improved quality, access, and outcomes. We review our measures annually, and adjust if needed, to assure continual alignment with MLTC priorities. We also adjust our measures in response to provider, member, and stakeholder feedback. We offer a wide variety of VBP options that drive the behaviors and the care we want to incentivize. These options range from primary care, specialty care, facility-based care, and other provider types to promote increased data collection for SDOH and health equity. Our VBPs never reward any provider or provider group for reducing or limiting medically necessary services to members, and we outline this in our VBP agreements. We evaluate provider and provider group performance for under-utilization and strictly prohibit any financial incentives linked to under-utilization.

[redacted]

[redacted]

All negotiated VBP arrangements are through a contract or a letter of agreement, and the provider must remain contracted and in good standing throughout the entire performance measurement period. The provider must also have no State- or CMS-issued sanctions during the measurement period. A sanction received during the measurement period will result in disqualification from any of the VBP programs. Our VBP program descriptions specify all applicable terms, definitions, requirements, performance measures and scoring, and payment methodologies for each of our VBPs. Our current Nebraska VBP programs, which focus on PCPs, specialty care, and facility-based providers, are still in their early stages. Since these programs are in their early stages in Nebraska, there are no results due to the limited time in operation in the State; however, we have successful results from these same programs in other markets. We list our current Nebraska programs and some highlights of success from other markets in Table V.Q.94-1.

[redacted]

[redacted]

[redacted]

Approach to Identifying Initiatives and Performance Measures of Focus

Stakeholder engagement in identifying VBP initiatives is essential. Involving providers and provider associations in the VBP planning and decision-making process creates an opportunity to gather feedback from those who will be participating in the program. Provider input is critical to determine what type and level of incentives would be meaningful to them and what barriers to participation might exist. We propose collaborating with the State to conduct listening sessions with providers, CBOs, and members to understand their goals, needs, and concerns prior to implementation of VBP programs. We know that linking providers with the CBOs that members trust in this effort will help us design appropriate methods and referral pathways that can improve coordination and member outcomes. We also recognize the value of empowering members to become active partners in their care and will seek feedback on meaningful ways we can incentivize their engagement in these programs, which will help to further improve health outcomes.

Provider Engagement Strategies to Encourage Provider Participation

Our guiding purpose is to coach, develop, and empower our Nebraska network providers, wherever they are on the continuum to value-based care, and to support our members through VBP and shared-savings arrangements. To drive greater engagement and results, we leverage our experience and relationships with Nebraska providers, and consistently seek feedback on program design through listening sessions and program evaluations.

[redacted]

Incentives Offered to Network Providers

We design our VBP programs to reward providers for effectively assessing member needs, coordinating member care, and collaborating with community stakeholders to successfully transition members between care settings. Our VBP programs reward collaboration in the service delivery system, which improves population health and helps to control costs, and we use prospective PMPM payments to support practice transformation and member engagement activities. Through our existing Nebraska VBP programs (listed in Table V.Q.94-1), we make sure providers across numerous specialty types are engaged and appropriately rewarded for supporting the State of Nebraska's goals. Our performance incentives encourage innovation and improvements in member outcomes, quality, access, and evidence-based clinical performance by providers.

[redacted]

Best Practices and Lessons Learned

From our VBP experience in Nebraska and our affiliate experience across the country, we understand that some providers may be hesitant to participate in VBP models for many reasons. For instance, some providers may not understand that a pay-for-quality model is upside-only, which means there is no risk in participation. We would seek to eliminate any reluctance by offering comprehensive training, as well as making sure providers have the right tools and support in place to make it easy for them to participate. We will partner with the State to develop resources that very clearly define all elements of the program, including billing requirements, incentive payment schedules, and expected outcomes. We also understand that a common barrier to provider satisfaction in VBP programs is accurate member attribution, which can impact provider incentive payouts. As a result, we propose that a panel review be incorporated into the quarterly meetings with providers to address any errors and mitigate this concern.

No. 95

Healthy Blue's MAC Program — Focusing on Fairness and Accuracy

Healthy Blue, in collaboration with IngenioRx, Inc. (IngenioRx), our affiliate Pharmacy Benefits Manager (PBM), maintains a proactive Maximum Allowable Cost (MAC) program that promotes generic utilization, cost containment, and fair reimbursements based on current marketplace pricing and product availability. Our program complies with all MAC laws and administrative regulations as set forth by the State of Nebraska's DHHS, the federal government, and as stated in SOW Q.20.

We have the following types of pricing that are part of 'lesser of' logic to save the State money:

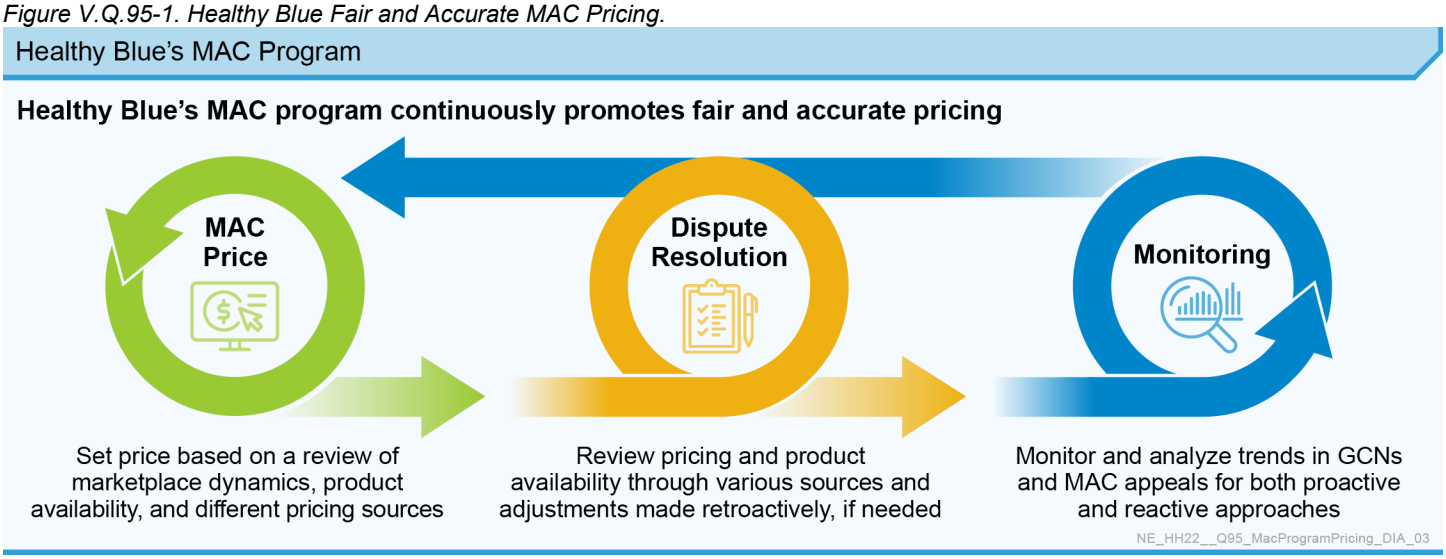
- Brands: Average Wholesale Price (AWP) – x% + dispensing fee
- Generics:
  - Non-MAC: AWP – x% + dispensing fee
  - MAC: MAC + dispensing fee
- Submitted Ingredient Cost + dispensing fee
- Usual and Customary

For generics on the MAC list, we maintain one proprietary MAC list under our MAC program with varying factors applied based on specific pharmacy categories. A description of our MAC program will be submitted to MLTC during Readiness Review for approval prior to Contract Start Date. The MAC list represents approximately 97% to 99% of generic claims, and it includes approximately 1,600 products with the various dosage forms and strengths of the same drug and with approximately 600 unique drug entities.

The MAC list includes generics and multi-source brand products, approximately 200 to 300 generics for which the MAC unit price for a commonly dispensed 30- and 90-day supply is comparable to low-cost generic promotion programs offered by retailers as their usual and customary price.

Our PBM reviews and updates MAC pricing weekly. Further, our process assures timely notification of the MAC pricing updates to network pharmacies. We make this information is readily available on our dedicated provider website and will provide a MAC file to the MLTC PDL contractor at least quarterly in the file format defined by MLTC. Figure V.Q.95-1 represents how we maintain a fair and accurate pricing process for our MAC program.

Figure V.Q.95-1. Healthy Blue Fair and Accurate MAC Pricing.



Methods for Setting MAC Prices

The MAC list development process involves a review of marketplace dynamics, product availability, and different pricing sources. Our PBM's generic pricing program will provide Nebraska Heritage Health an advantage by combining broad coverage with competitive rates for generic products and by promoting generic utilization. Generic products represented on the MAC list are established at a generic class level for a consistent price regardless of manufacturer.

Our PBM's analytical and proactive method for setting MAC prices continually surveys the market for price changes. Our PBM performs timely and regular updates and validates product availability through pharmacy and wholesaler communications. This generic pricing program is monitored based on Nebraska's utilization, and prices are adjusted up or down based on current market prices.

Our PBM determines the most MAC marketable price through an algorithm at the Generic Product Identifier (GPI) level based on:

- Medi-Span
- MAC lists published by CMS
- National Average Drug Acquisition Cost (NADAC) published by CMS
- Predictive Acquisition Cost (PAC) developed by Glass Box Analytics
- Wholesalers and retail pharmacies
- Wholesale Acquisition Cost (WAC)
- Published, online retail costs

Some claims subject to MAC pricing may adjudicate outside of MAC pricing, depending upon claim-specific factors, such as:
- The submitted usual and customary price
- Plan design
- Non-MAC generic discount
- Submitted Dispense as Written (DAW) code

Our "lesser-of" adjudication logic settles the claim at the lowest applicable price (not routinely below the wholesale price available to pharmacists). Additionally, brand preferred products are paid at the brand reimbursement price.

There is typically one unit MAC price across all package sizes and National Drug Codes (NDCs) for each generic product. However, there may be some instance where a generic product may have multiple MAC prices if pricing is established at a package size or NDC level.

Our PBM's analytical process to establish a MAC is at a product level for generics and multi-source brand products.

Criteria for Covered MAC Drugs

Prescription drugs will be placed on the MAC drug list based on the following criteria:
- Bioequivalence to the brand product
- Number of manufacturers in the marketplace
- Product availability
- Claims volume
- Presence in the market past the exclusive generic time-period
- Product is rated by the FDA in relation to the innovator Brand Drug (A-rated by the FDA Orange Book)
- Marketable discount difference between price per unit versus what could be captured through a discount off AWP
- Price differences between the brand and generic products
- Clinical implications of generic substitution

Our PBM adds new bioequivalent generic drugs to the MAC list for our generic pricing program applicable to the Heritage Health plan no more than 30 days after they are readily available from more than two generic suppliers. We base MAC cost limits on an ongoing review of Medi-Span AWP and WAC, competitive intelligence information, and published online/retail resources (from sources such as CMS, GoodRx, Drug.com, and others).

MAC Dispute Resolution

Our PBM has an established process to assure that MAC pricing is appropriate and not routinely below the wholesale price available to state pharmacists. On the rare occasion disputes occur, our PBM has an appeals process. The pharmacy provider handbook provided to a contracted pharmacy includes the process to appeal disputes regarding MAC pricing. Pharmacies submit MAC paid claim appeals through the pharmacy provider website. Chain and affiliation (pharmacy services administrative organization) pharmacies can submit MAC appeals through their chain or PSAO headquarters, which then submits the information to our PBM. Submission of a paid claim by the pharmacy is required for this process. The provider must notify the PBM and provide the following information: date of fill, prescription number, NDC number, drug strength, dosage form, member ID number, and pharmacy National Council for Prescription Drug Programs (NCPDP) and National Provider Identifier (NPI) number.

The administrative appeals process allows a dispensing provider to contest a listed MAC rate:
- All MAC appeals are reviewed and responded to within seven calendar days, and price adjustments are made as appropriate.
- The review process includes a verification of pricing and product availability through sources of information such as Medi-Span, NADAC published by CMS, PAC developed by Glass Box Analytics, and if available, wholesalers and retail pharmacies.
- The MAC team complies with applicable State laws regulating MAC management; changes are made retroactive to the date of service and adjustments are effective for all pharmacy providers in the network.

Our PBM has a monitoring process that analyzes MAC appeals through monthly reporting, and highlights outliers regarding specific drugs and pharmacies, which may prompt investigation into pricing sources.

Healthy Blue's MAC Program Evaluation

The MAC list and associated pricing is reviewed continuously, and updates made as often as weekly based on marketplace trends and dynamics. Our PBM monitors the list for appropriateness by continually surveying the marketplace for price changes and performing timely and regular updates to the MAC list weekly. MAC prices may be adjusted upward or downward depending on current market pricing and availability. Supply issues are validated via information obtained from wholesalers, manufactures, retail pharmacies, and Medi-Span.

Our PBM develops a MAC list that includes evidence of all recent changes, including additions, deletions, and adjustments. There is also data supplied relating to MAC changes resulting from MAC appeals. These files are reviewed monthly to assure the generic effective rate and to validate pharmacy generic reimbursement rates are aligned to expected performance.

At Healthy Blue, we evaluate and monitor the MAC program using different approaches:
- **Proactive.** Review of reports to analyze and recognize trends regarding Generic Code Numbers (GCNs) being filled so our PBM can look at various pricing sources to assess if the MAC is priced appropriately.
- **Reactive.** Review of reports to analyze and recognize trends in MAC appeals so our PBM can look at various pricing sources to assess if the MAC is priced appropriately.
- **Stability.** We also understand the difference in buying power between independent and chain pharmacies and look at trends with retail independents versus chains to assure independent pharmacies are successful, paid fairly, and stay in network.

Healthy Blue is committed to full transparency, and we maintain an established oversight program in Nebraska that is enhanced by national expertise and experience. We conduct on-site audits of our PBM and will submit a plan for oversight of their performance prior to the Contract Start Date. This plan will be submitted a minimum of 90 calendar days prior to the intended Contract Start Date for review and approval by MLTC. We will assure our PBM complies with this contract and all MLTC requirements (SOW 4.a.iii).

A component of our PBM audit is on claim adjudication to assure pharmacy claims are paid at the appropriate MAC unit price. We also assure that MAC appeals are being handled based on State regulations including audit response times.

Additionally, every day, our PBM monitors dispensing pharmacy claims to identify outliers and to help promote safety and compliance with laws and government regulations. Built-in audit tools, fraud tip hotline, and various other monitoring resources help reduce the potential for fraud, waste, and abuse. A proprietary audit algorithm involves a continuous automated review of the entire claims database, identifying outlier pharmacies and claims, as well as variety of other audit procedures.

We will submit policies and procedures about MAC pricing to MLTC for review and approval a minimum of 120 calendar days prior to the Contract Start Date. We will also continually develop and maintain a Nebraska-specific policy and procedure that meets State and federal requirements for providing brand-name products when the prescriber appropriately determines and documents that the brand-name product is medically necessary. We will override the MAC on preferred drug list products when the name-brand product is preferred over the generic. MAC pricing will not apply to the name-branded product if the product was approved to be dispensed as medically necessary.

Other Program Components for Achieving MLTC Goals

Healthy Blue has a wide range of experience integrating and adapting our Pharmacy Management programs to meet the State's managed care goals. We work collaboratively with MLTC on specific goals and provide recommendations based on our experience. We will leverage this collective experience to customize our program and control outpatient drug costs specific to Nebraska's managed care program.

We continuously look for ways to improve and to identify innovative approaches to increase access to care and realize cost-savings. We are currently championing pilot programs nationally for alternative reimbursement strategies that will promote generic utilization and cost containment that may be used for the Nebraska Heritage Health program and align with State goals. Our Pharmacy Director will collaborate with the Nebraska Pharmacy and Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Board for consideration and approval of shared best practices that will identify and implement clinically based, cost-effective pharmacy initiatives throughout the state, especially in rural areas.

We understand the importance of network satisfaction, the balance between saving money and paying pharmacies appropriately, and the challenges rural pharmacies face because they do not have the same buying power as chain pharmacies. We are committed to building strong relationships and assure all local pharmacies have access to fair pricing. It is a priority of ours to keep independent pharmacies in network to continue to meet geo access standards.

Healthy Blue's MAC Program Experience in Other States

Healthy Blue has been overseeing pharmacy benefits in Nebraska including the MAC program since January 1, 2017, when the pharmacy benefit was carved into managed care. When we transitioned the pharmacy benefit to IngenioRx on January 1, 2021, with prior approval from DHHS, we smoothly and seamlessly transitioned more than 100,000 members and experienced no significant issues.

Our PBM employs a team of industry experts knowledgeable in both the generic manufacturing and retail pharmacy industries to provide competitive generic pricing while encouraging generic utilization.

Our PBM currently manages the integrated pharmacy benefit in 15 additional Medicaid markets for more than 6.5 million Medicaid members including managing clinical programs to improve member adherence, reduce polypharmacy, close gaps in care, and support a variety of HEDIS® measures. IngenioRx oversees the MAC program in 12 of those markets. [redacted]

Our PBM has extensive experience managing Medicaid pharmacy programs, including MAC pricing programs. Our PBM's team of industry experts continuously research and create ways to adapt to pharmacy costs while making sure members have access to care and the medications they need. Our programs have been highly effective, and we regularly look for ways to innovate and provide alternative reimbursement strategies. We will use our PBM's experience and pilot programs in Nebraska. Our collaborative approach with the State will be presented to Nebraska's P&T and DUR board for approval and consideration.

Strengths and Challenges

Healthy Blue's primary strength is our collaboration with our affiliate PBM and the ability to leverage our PBM's national experience with MAC programs. Our PBM oversees the MAC program in Nebraska and 12 affiliate markets, bringing combined experience, lessons learned, and successes in other markets to our MAC program. For example, based on proven effectiveness and outcomes of pilot programs in other markets — we can implement similar programs for alternative reimbursement strategies in Nebraska that will promote generic utilization and cost containment.

We mitigate pharmacy MAC appeals and potential confusion around pricing fluctuations by providing a consistent, stable approach to developing fair and competitive MAC pricing. We assure providers have access to MAC pricing and appeal information.

We structure pricing to assure we are supporting product growth with competitively priced "most used" drugs. Independent pharmacies, especially in rural areas, face challenges due to lower volume of prescriptions and increased buying limitations. As such, we look at trends specific to independent pharmacies and set MAC rates that cover pharmacies with low volume and low buying power.

We will work with MLTC to assure we are always taking a proactive and collaborative approach to share successes, addresses challenges, and provide solutions.

No. 96

Arranging Out-Of-Network Services

Healthy Blue maintains continuity of care and augments any in-network service gaps when medically necessary services are not available from an in-network provider through a single-case agreement (SCA). In alignment with the SOW, we assure, if applicable, the cost for the services is no greater than it would have been if the services were furnished within our network and that member copays are no greater than if the services were furnished within our network. We have a comprehensive approach to make sure we build a network that not only meets but exceeds access and availability requirements in Nebraska. Our utilization management (UM) team immediately verifies member eligibility and confirms providers are licensed and not excluded from participation by DHHS, the Office of Inspector General (OIG), and MLTC. Our Chief Medical Officer and the UM team verify the case is medically necessary. This process is documented in our Core Service Platform (CSP) upon confirmation and during negotiation. Routine, non-urgent SCAs are processed within five business days, and urgent ones within one business day. Additionally, our Provider Contracting team assesses SCA requests to identify providers to join our network. This process has resulted in ***more than 80% of providers that request SCAs being recruited into our network nationwide***. Additionally, if a member is in care management, our care management team will coordinate out-of-network services.

Our SCAs specify mutually agreed-upon reimbursement terms and conditions, including quality and accessibility standards and requirements related to nationally recognized standards of care. Open cases are reviewed daily by our UM Clinician for care coordination and to resolve potential barriers and assure any issues are resolved expeditiously. Our UM team monitors closely to make sure the member receives quality care, and if issues arise, we address them immediately and resolve them or switch providers to address member needs — including providers outside their specific geographic area if it means better access to care. We arrange transportation, telehealth appointments, and mobile services if needed as well.

Prior Authorization and Payment

We continually monitor our provider network to assure network adequacy standards are maintained; however, if a member needs a service outside of our network, we work diligently to timely arrange these services by expeditiously resolving any prior authorization and payment issues. To fully support member continuity of care, we pay out-of-network providers at 100% of the Medicaid fee-for-service (FFS) rate for the 1st 180 calendar days of our contract with MLTC, and we continue to pay for member services for the duration of the prior-authorized services.

We do not require authorization for an emergency service. We also comply with Section 6085 of the Deficit Reduction Act of 2005 by paying claims for emergency and post-stabilization services provided to our members by out-of-network providers at 100% of the Medicaid rate in effect on the date of service. For family planning services and related supplies from appropriate Medicaid providers outside of our network, the out-of-network provider bills us and is reimbursed at the Medicaid rate in effect on the date of service. We encourage members to receive family planning services through our network of providers to assure continuity and coordination of their care, and we understand that we will receive no additional reimbursement from MLTC for members who elect to receive family planning services outside our network.

We keep all criteria current and distribute criteria for approval or denial of out-of-network services to all non-network providers to whom members are referred. We employ payment protocols for out-of-network providers, and our CSP is configured so that codes for emergency services are paid to all providers. Our CSP does not apply the edit for provider network status when adjudicating a claim submitted for emergency services and applies other appropriate edits such as confirming a patient was a member on the date of service. As a result of this standard system configuration to pay emergency claims, ***in 2021, across affiliate markets, our out-of-network providers were, on average, paid as fast as our in-network providers*** despite the extra time required to configure our CSP for the initial out-of-network provider billing. Our process for submitting all provider claims, including out-of-network providers, is available on our public website, and any provider may call our Provider Services Call Center with claims submission or other questions.

Supporting Out-Of-Network Providers. We offer comprehensive and personalized customer service for providers through our Provider Services Call Center. Clear and consistent communications are central to our partnership with all providers, including out-of-network providers. Our Provider Services Call Center is a critical component of those communications and our partnership with all providers to best meet member needs and streamline provider interactions.

For maximum efficiency, provider calls are routed to our Provider Services Representatives (PSRs), who are specifically trained to support Heritage Health providers. Specifically, PSRs are trained in assisting providers with prior authorizations, referral procedures, claims payment procedures, member eligibility status, billing, disputes, and grievances. PSRs are ***trained to resolve issues and concerns on the 1st call***, and they have access to the latest information — both data and processes — through our knowledge base, which is updated in real time. Providers can also be quickly directed to our specially trained claims processing PSCCRs to expedite and resolve claims concerns on the 1st call. Our PSRs help providers with the administration of out-of-network services as well as other services, including:

- Prior authorizations and notifications not requiring clinical review
- Prior authorizations requiring clinical reviews, which are handled by UM Clinicians
- Claims issues, including telephonic adjustments
- General administration calls
- Web support calls

We provide this support to out-of-network providers to assure continuity of care for our members and because we know providers are more willing to join and remain in our network when they know their issues or concerns are addressed and resolved expeditiously. Additionally, we are ***adding a Senior Network Manager to support providers and encourage them to join our network***. This FTE will be devoted to working with providers to incentivize them through innovative ways and through their contracts to address any network gaps. The FTE will work with medical, facility, behavioral health (BH), and ancillary providers to assure member needs are met through our network.

Adding Out-Of-Network Providers to Our Network. We have a long-standing, stable network with more than 25,000 providers, and we continually work to enhance the accessibility of providers for our members. In 2021, we expanded our network by contracting with more than 150 new facilities and 114 providers and provider groups. We continually monitor our provider network to assure network standards are maintained for all provider types, and this work includes bringing out-of-network providers into our network. We host quarterly Network Access workgroups to understand any access to care challenges and work resolve them. We monitor service utilization patterns, including utilization of the emergency department (ED) and inpatient admissions and readmissions, to identify specific communities where there may be to recruit providers to increase access to care. We also ***monitor out-of-network utilization and SCA requests to identify potential access gaps and encourage out-of-network providers to join our network***. To assist this process, on a quarterly basis (or more frequently as needed), we review and analyze:

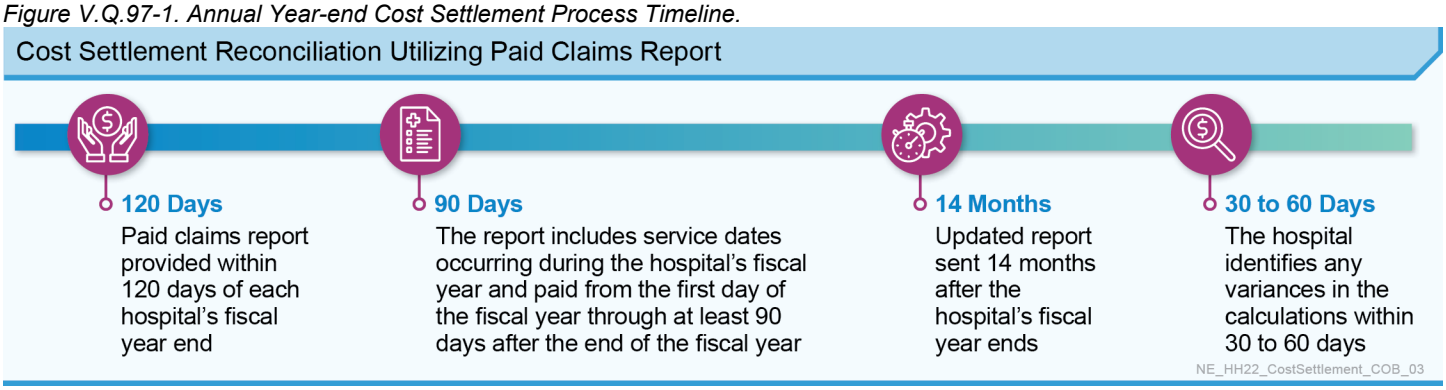
- **Geographical Adequacy Reports.** Complete network adequacy reports identify areas of geographic network gaps and regulatory compliance at the ZIP code, county, and statewide levels based on MLTC standards. We evaluate access and capacity using an industry-standard tool that generates geographic overview maps, provider and member location maps, member accessibility summaries, and detailed accessibility reports.
- **Health Equity Assessments.** Health equity assessments determine languages spoken by our providers and members, capturing physical access information for each provider location and using data to map access for members with disabilities. Our Quality Management team routinely evaluates social determinants of health (SDOH), clinical utilization, and outcome data to identify health disparities by factors such as race, ethnicity, and geography.
- **Access and Availability Audits.** Access and availability review is done regularly on a statistically significant number of providers, measuring their compliance with appointment scheduling timeframes as set forth in our contract with MLTC, and we exceed those requirements by conducting them more often than requested.
- **Complaints, Grievances, and Appeals.** Monitor complaint, grievance, and appeals data to gauge access to care concerns, as well as monitor and resolve issues. This data helps support access to efficient and evidence-based care, detect underutilization, and implement and evaluate network improvements.

No. 97

Annual Year-end Critical Access Hospital Cost Settlement Process

Healthy Blue makes all critical access hospital (CAH) inpatient payments using the per-diem rates calculated by MLTC with an annual year-end cost settlement, which occurs at the end of each CAH's fiscal year. With each CAH operating on its own specific fiscal year, each hospital's financial reconciliation (cost settlement) is dependent on that particular hospital's fiscal year end date. To accommodate the different fiscal year end dates, we work closely with hospitals on an ongoing basis and provide a paid claims report to each facility (and, if required, MLTC) 120 days after the end of each hospital's fiscal year. One hundred twenty days is the timeframe typically needed to produce a paid claims report accommodating 90 days of claims runout. We are currently contracted with all the CAHs listed in Attachment 8 provided as part of RFP 112209 O3. Our paid claims report includes both inpatient claims and outpatient claims, and its timeline is highlighted in Figure V.Q.97-1. The paid claims report also includes both covered and non-covered charges identified by cost center using revenue codes. Payments made by Healthy Blue are listed with any third-party liability (TPL) payments and member cost sharing. For inpatient claims, both the discharges and days are included on the report. The hospital's draft cost report submitted to the state is then compared to our report. We work with the hospital to timely solve any issues and come to an agreement on the final number. We also proactively reach out to CAHs and compare data to assure the settlement amounts are correct. This complicated reimbursement process requires a lot of collaboration between our Provider Experience team and the CAHs to agree on the correct amount, and we provide a level of support that makes this complex process easier for CAHs. We work with CAHs to verify the calculations prior to payment, and we allow them to provide their own data comparisons. CAHs also provide us with a written acceptance of the settlement amount prior to payment.

Figure V.Q.97-1. Annual Year-end Cost Settlement Process Timeline.



The outpatient cost to charge ratios (CCRs) by cost center represents the initial cost settlement, and it is due to the state five months after the hospital's fiscal year end. This initial reconciliation provides us with insight into any potential liabilities owed and changes to the hospital's CCRs prospectively, which will impact our spend run rate with the hospital. We work with our Actuarial team to accrue these items as appropriate.

We conduct a final reconciliation for each CAH after DHHS Financial Services has reviewed, approved, and published the final Medicaid cost report confirming the approved CCRs for the hospital. Once we receive the final Medicaid cost report from DHHS, the CCRs for each cost center will be applied to the covered charges to calculate reasonable cost of services for each cost center. The reasonable cost for each cost center will be compared to our payments plus any member cost sharing amounts to determine whether any additional payment is owed to the CAH or due back to us. Any services and TPL claims not reimbursed on a cost basis, such as flat triage fees or outpatient services paid on a fee schedule, are excluded from the settlement calculations. The settlement calculations are communicated to the hospital for final reconciliation. Our process repeats for each hospital for each fiscal year.

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As an incumbent MCO in Nebraska, Healthy Blue has configured our systems to support Nebraska Heritage Health program operations under current contract requirements. We have reviewed the SOW to assess capabilities and identify any potential system changes to incorporate enhanced requirements and proposed new capabilities. Our Management Information System (MIS) is compliant, fully integrated, and operational in Nebraska and will require no system changes to meet contract requirements. Healthy Blue's highly effective, HITRUST-certified, and HIPAA-compliant MIS effectively manages clinical and health care services data and provides critical support for health care operations. We adhere to SOW requirements R.9.f–R.9.j regarding physical safeguards securing Healthy Blue's MIS, conduct security risk assessments and penetration testing annually in compliance with SOW R.9.k, and adhere to data-protection requirements in SOW R.9.m.i–R.9.m.iii and records retention requirements in SOW R.13.a–R.13.b.

Our MIS configuration is based on our and our affiliate health plans' experience serving 10.9 million members in Medicaid managed care programs in 26 markets nationwide. Our integrated system supports seamless operation of all managed care functions using modular component integration. This gives us flexibility to implement the functions necessary to meet the needs of our members, providers, partners, and community organization stakeholders in Nebraska. Our organizational structure allows us to share lessons learned, innovations, and capabilities developed in Nebraska with our affiliates, and to bring tested solutions from other markets to Nebraska.

We maintain systems, processes, and staffing necessary to comply with SOW requirements, including interfaces and data exchange with MLTC and providers. Our Information Management and Systems Director directs integration between system components and functional areas they support, as well as interfaces and data exchanges with external partners. We are prepared to provide MLTC with live access to all its systems at any time in compliance with SOW R.1.c. Healthy Blue staffs and operates a systems help desk capable of answering questions and resolving problems as required by MLTC (SOW R.3.a) and maintains written systems policies and procedures (SOW R.3.b). We will notify MLTC of changes to its systems a minimum of 90 calendar days prior to the projected date of the change (SOW R.3.c.iii), will provide MLTC an annual systems refresh plan (R.4), and will provide a continuously available electronic mail communication link (email system) to facilitate communication with MLTC (SOW R.7.a) and, as needed, communicate with MLTC using encrypted email over a secure transport layer (SOW R.7.b).

Our MIS is comprised of five key systems and platforms that support our core operations.

- **Core Service Platform (CSP).** Our CSP, TriZetto's Facets®, serves as the system of record for member data (including demographics, enrollment, and other insurance coverage), health plan benefits, providers, service authorizations, claims and encounters, and finance. It meets the contractual requirement for a centralized communications database that stores the member's primary language information and other special communication needs. These needs include visual or hearing impairment, or auxiliary aids or services, as well as provision of such services. We maintain data quality through interfacing applications that apply rules-based standardization, verification, and validation logic to data elements.
- **Health Intech Platform.** Our care coordination platform integrates seamlessly with our CSP and data warehouse. It hosts member and provider portals to share member information with Nebraska Medicaid members, providers, and all entities involved in coordinating their care. It provides tools for the Care Management team and providers to identify and manage member needs, including care plan development, coordination, and communication.
- **Sydney Health (Sydney).** Available 24/7/365, this digital health hub for members uses artificial intelligence (AI) and data science to harness the power of Healthy Blue's data and deliver a personalized, intuitive health care experience for each member by:
  - Integrating benefits, claims, health, and wellness
  - Tailoring content to each member's unique needs
  - Recommending products and programs and identifying gaps in care to deliver better outcomes at lower costs
  - Engaging members to help them achieve goals
  - Making it easy for members to choose how and when they interact with us (text, chat, email, telephone)
  - Delivering an integrated, seamless experience, whether members use the website or mobile app
- **Provider Website.** Available 24/7/365, with public and secure self-service areas, we designed this website to facilitate easy navigation and give providers access to actionable information. The provider website delivers timely and relevant information, including:
  - The latest provider communications
  - Reimbursement policies and billing instructions
  - Our Prior Authorization Lookup Tool (PLUTO)
  - Provider online chat
- **Data Warehouse.** Using a SQL Server platform, and fed directly from the system of record, our data warehouse delivers a comprehensive source of health information about members, including encounter claims data for medical, behavioral health (BH), social determinants of health (SDOH), pharmacy, dental, and transportation services received. It supports operational processes, advanced analytics and data modeling, quality management and improvement, and reporting. We integrate additional information into the data warehouse to support other processes, including lab results, immunizations, prescriptions, and other clinical data to be used for utilization and care management.

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Healthy Blue's MIS, as shown in Diagram V.R.98-1, shows the data interface framework that supports all functional areas of our health plan. Healthy Blue's systems use common industry transaction standards to ensure interoperability between internal and external systems, including with the State and other key trading partners. Data received from members, MLTC, providers, subcontractors and our partners are accessible to support the Nebraska Medicaid program goals. Data collected by one process is available to all related processes and applications — even those supported by different system components.

Robust, well-designed systems and processes have made it easier for Healthy Blue to actively partner with MLTC on the exchange of timely, complete, and accurate data. We conform to HIPAA compliance standards as well as all State and federal standards for data management and information exchange. As a partner to MLTC, we have established processes and protocols to support special reporting and data requests as new federal or State mandates emerge. Healthy Blue will readily comply with new regulatory reporting requirements by creating additional reports or modifying existing ones as directed by the Agency.

We promptly configure and implement required data extract changes as outlined in the contract and defined by MLTC. We use mutually agreed-upon formats and data exchange protocols for all required electronic standard and real-time health care transactions, including X12 and National Council for Prescription Drug Programs (NCPDP) formats. Batch and real-time data exchanges are fully automated with internal procedures and system-based controls to monitor timing, format, and data integrity.

Healthy Blue is compliant with the most recent versions of all the electronic data interchange (EDI) transactions and the national code sets as required by the State. We are 5010 compliant, and we comply with the State's Companion Guides and interface with major clearinghouses to support data exchange between Healthy Blue and our providers. Our privacy, security, and transaction code sets are HIPAA-compliant. We accept and transmit HIPAA-standard transactions, including 834, 837 (I, P, and D), 835, 820, 276/277, 277CA, 271U, 270/271, 278, and 997/999 formats. We are compliant with the 5010 standard for these transactions and also support the NCPDP D.0 standard. Our MIS uses industry-standard medical billing taxonomies, including HCPCS, ICD, DSM-V, CPT®, revenue, CDT/ADA, and National Drug Codes (NDC) codes. In addition, we maintain and use HCPCS Level II and Category II CPT codes. We load updated code sets promptly with effective dates so transactions, reporting, and data analytics reference the correct information. Edits validate codes in claims we process and in encounters we receive from our subcontractors prior to submitting encounter data to MLTC. To comply with Nebraska Medicaid National Provider Identification (NPI) requirements, Healthy Blue applies enhanced edits and checks regarding provider NPI attestation in our claims processing and encounter management systems. Our use of industry data transaction standards supports our automated electronic exchange of data with the State. Our frequent exchange and reconciliation of data with the State and rapid implementation of policy changes in our systems help to avoid duplication of effort. Table V.R.98-1 shows a sample of some of the inbound and outbound data files that Healthy Blue exchanges with the State.

Table V.R.98-1. We Routinely Exchange Multiple Data Files with the State.

Inbound/Outbound	Functional Area	File Name	File Type
Inbound	Care Management	Prior Authorization and Care Management	Proprietary State Format
Inbound	Encounters	Response File; TA1	Electronic Data Exchange
Inbound	Encounters	277CA Response File	Electronic Data Exchange
Inbound	Enrollment	Unborn File	Proprietary State Format
Inbound	Enrollment	HIPAA 5010 834 Transaction	Electronic Data Exchange
Inbound	Enrollment	Coba – Eligibility Responses	Proprietary CMS Format
Inbound	Finance	Maternity Care Payment Reports (NMC605)	Proprietary State Format
Inbound	Finance	820 Transaction	Electronic Data Exchange
Inbound	Provider	State Medicaid Provider File to Plans	Proprietary State Format
Inbound	Provider	Provider Sanction File	Proprietary State Format
Outbound	Claims – Pharmacy	Restricted Services File	Proprietary State Format
Outbound	Encounters	837p Encounters Transaction	Electronic Data Exchange
Outbound	Encounters	NCPDP Input File (Encounter)	Electronic Data Exchange
Outbound	Encounters	837i Encounters Transaction	Electronic Data Exchange
Outbound	Encounters	HHEB PCP Assignment File	Proprietary State Format
Outbound	Finance	Maternity Care Payment Request Submittal	Proprietary State Format
Outbound	Provider	Plan Provider File to State – Request	Proprietary State Format

Eligibility, Enrollment, and Disenrollment Management and Data Exchange

Complete, timely, and accurate member data is critical to support major operational functions, including utilization management (UM) and claims processing. Healthy Blue has configured our CSP as the system of record for all member data, including current and historical demographic and eligibility information. We control updates via role-based access to the user interface or application-specific data loads, such as MLTC's 834 enrollment files. We maintain an audit trail of all changes made to each member record. Applications interfacing with our CSP map to data structures for consistency in naming, formatting, validation, data quality, and reliability. Diagram V.R.98-2 provides a flow diagram for member eligibility, enrollment, and disenrollment management, including intake and downstream processes.

Timely Enrollment Processing. We have customized a comprehensive enrollment load process to support MLTC's enrollment processes and requirements. As necessary, we add or update member demographic and eligibility information using data from daily and monthly X12 834 files and monthly X12 820 capitation files, according to MLTC timelines. We maintain complete eligibility history for all members, using uniquely dated spans to manage variation in benefit category and product — maintaining a complete timeline of participation in the Nebraska Medicaid program. Our enrollment processes are fully configurable and handle prospective and retroactive enrollment, with no limit on the timeline for accepting retroactivity. We maintain automated processes to recoup provider payment due to a member's retroactive disenrollment. As MLTC notifies us of new members through 834 files, we assign a unique ID to track and manage individuals throughout all systems within our control, including subcontractors. To better track and aggregate information and improve care delivery, this number stays with members as they move between benefit plans and products. We also maintain and protect members' Social Security numbers and State-assigned Medicaid IDs.

The automated load process flags suspected duplicate records for review prior to updating or creating member records. This prevents potential member service disruption, provider claim issues, or accumulator reconciliation issues. Our Enrollment team works with MLTC to make final determinations on disposition of records identified as potential duplicates.

Member Reconciliation. Healthy Blue performs several reconciliations each month for Nebraska Medicaid member eligibility, using daily and monthly 834 files and monthly 820 files. Our process reconciles daily 834C files to monthly 834F files. We report discrepancies between daily and monthly enrollment files in the format specified by Nebraska and within one business day for discrepancies that would negatively affect member access to care. We compare the State's 834 and 820 files to data in our integrated system to identify members on the 834 or 820 file who are not in our system and members in our system who are not included in 834 or 820 files. We use enrollment data to make important linkages and close gaps in care. For example, in Member 360°$_{SM}$, we can view all family members and check for any care gaps while we are on a call with a parent.

The reconciliation process generates discrepancy reports, which our Enrollment and Billing teams carefully review. They add members on the 834 or 820 files who are not already in our system and initiate new member processes. For those in our system but not on 834 or 820 files, we review all enrollment data previously received to confirm we did not receive a termination record. We submit discrepancies and reconciliation requests to MLTC no later than 60 calendar days after receiving the monthly 820 remittance advice.

Data Exchange. Supported by flexible data exchange systems and procedures and an experienced Data Exchange team, we can readily work with MLTC, subcontractors, providers, and other supporting entities to establish mutually agreed-upon data exchange protocols to exchange data to support day-to-day operations or provide seamless transition for members transferring between MCOs.

We currently connect with MLTC and support all electronic standard health care transactions mandated by MLTC, including X12, NCPDP, XML, and JSON formats. Batch and real-time data exchanges are fully automated, with internal procedures and system-based controls to monitor the timing, format, and integrity of all data exchanges.

Technology Services uses encrypted file transfer protocols to secure Protected Health Information (PHI) exchanged both within and outside of Healthy Blue. We will continue to take full responsibility for the transfer of information in the required format(s) and verify that MLTC or the designated recipient receives and verifies the information. We will continue to provide data layouts, reference tables, and other supporting documentation as necessary.

Disenrollment for Reasons Other Than Lack of Medicaid Eligibility. Under certain circumstances, a member may request to be disenrolled from Healthy Blue or Healthy Blue may request that the member be disenrolled from them. A member may request disenrollment without cause during the 90 days following the date of the member's initial enrollment with Healthy Blue or during certain other time periods. After the 90 days following the date of the member's enrollment with the Healthy Blue, when the member is requesting disenrollment due to good cause, the member first makes a verbal or written filing of the issue through Healthy Blue's Grievance System. If the member does not experience resolution, Healthy Blue directs the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call and must request a good-cause change for enrollment. Good-cause changes include the following:

- Healthy Blue does not, because of moral or religious objections, cover the service the member seeks.
- The member needs related services to be performed at the same time, and not all the related services are available with Healthy Blue, and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- The contract between Healthy Blue and MLTC is terminated.
- Lack of access to benefits and services covered under the contract.
- Other reasons, including but not limited to poor quality of care, or lack of access to providers experienced in dealing with the member's health care needs.

Under certain circumstances, Healthy Blue may request that the member be disenrolled from them. Healthy Blue will only request that a member be disenrolled if we have sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the member, including circumstances in which the member misuses or loans the member's ID card to another person to obtain services, or if the member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in Healthy Blue seriously impairs our ability to furnish services to either the member or other members.

Provider Network Management, Certification, Enrollment, Notification, and Confirmation File Exchange

Provider data is stored in our CSP, including demographic data, provider type, specialty codes, licensing and credentialing information, PCP capacity, reimbursement rates, fee schedules, payment information, and data necessary to publish the provider directory. We validate format and consistency of all data and edit against specific functional business rules, controlling user interface updates through role-based password access. As directed by MLTC, we provide documentation verifying accuracy of all information submitted to MLTC's provider network management system. We maintain an audit trail of all changes made to each provider record, including effective start and end dates for credentialing, licensing, registration, and network status. We provide a diagram for our provider enrollment and network management systems and processes in Diagram V.R.98-3.

Submission of Provider Network Information. Healthy Blue maintains provider data necessary to support Medicaid operations. We comply with MLTC's reporting requirements and submission of provider network information.

Monitoring Provider Network Access Requirements. Healthy Blue uses information gathered and stored in our CSP to generate provider network reports. We use geographic access reporting features to evaluate network adequacy.

Provider Billing and Claims Support. We use specific provider data elements to edit and process claims according to MLTC's requirements, including provider type, NPI, taxonomy, location, and category of service. We track information on the provider record for use during adjudication to prevent claims payment, including sanction status and Clinical Laboratory Improvements Amendments Certificate of Compliance.

Member and Provider Information Access

Member Access Through Sydney. According to a 2018 study by Deloitte, 86% of Medicaid beneficiaries own smartphones and 69% own tablets. In our experience, members are eager to use these tools to improve their health; Healthy Blue's answer to this is Sydney, a digital health home tool that recognizes a member's health journey should not require multiple calls, apps, or internet searches. Going beyond the traditional member portal and website or app format, Sydney provides members with tools and resources customized to their health history and interests. Sydney offers answers to questions that matter most to members and directs them to the right care resources in real time. Using AI and data science to personalize each members' experience, Sydney increases engagement and makes health care smarter, easier, and more accessible than ever before.

With Sydney, members can seamlessly move from one valuable resource to another and check symptoms, visit with a provider in real time, or send needed prescriptions straight to their pharmacy of choice. Sydney delivers an unparalleled, convenient, personalized experience that removes barriers to care. Simply stated, Sydney is where health meets wellness — and wellness meets care.

24/7/365 Provider Portal and Website. Healthy Blue's secure Availity provider portal offers the latest communication and toolkits to make providers' jobs easier. Providers can access Nebraska Medicaid information through the Payer Spaces section and easily view formularies and reimbursement policies. Providers can access PLUTO via the provider portal and the public website. The public website delivers timely and relevant information, announcements, alerts, forms, and a list of Provider Experience Representatives by region for providers, staff, and stakeholders. In addition, providers have access to Patient 360°SM, part of our Health Intech platform, through which they can access member records.

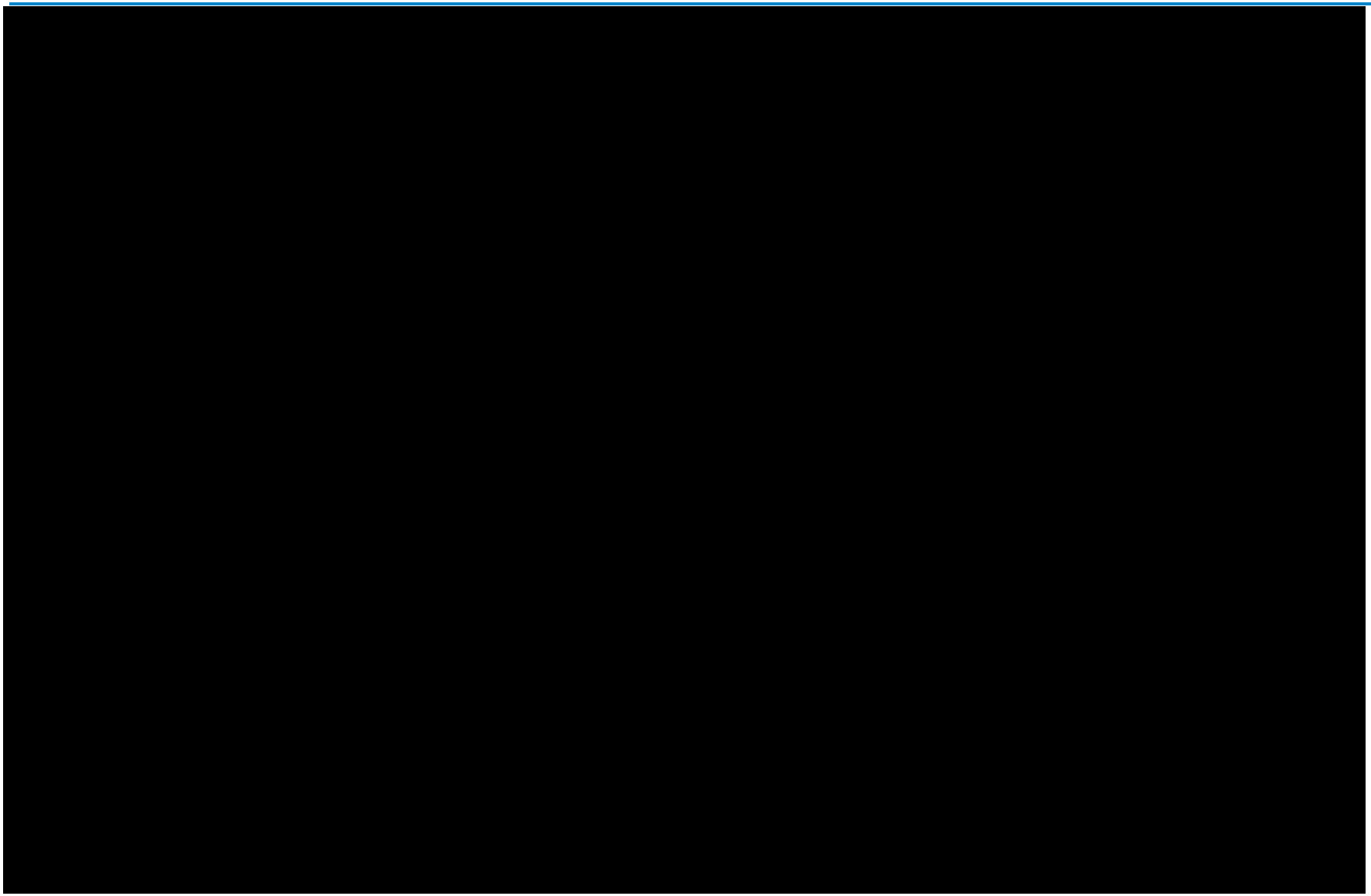
To support provider authorization requests, the provider portal and the public website include evidence-based trainings and tools, such as clinical practice guidelines, member eligibility, and medical policies. Training and tools are available for providers in our Medicaid provider Training Academy on the public website. For example, providers can find support for on-demand video training, online registration for live trainings, and the ability to self-report completed trainings.

Our Provider Experience team offers a personal level of provider support on a range of topics such as claims submission, new requirements, changes, or corrective actions. Training is offered during orientation and through regular updates through our provider website, as well as faxes and e-blasts. Education is tailored to providers and offered virtually or in person, and we attempt to correct claim-processing errors with providers in ***real time*** by phone.

Provider Technical Assistance for I/T/Us, Rural Health Clinics, FQHCs, SNFs, and Other Specialty Providers

Technical assistance for I/T/Us, Rural Health Clinics, FQHCs, SNFs, and other specialty providers is available through our EDI Solutions Center team. This team facilitates referrals to the appropriate resources and works with providers to resolve issues related to initial setup, data- or format-specific problems, and overall assistance submitting claims. Training and education curriculum is tailored to meet provider needs. We offer providers training and education that is easy to understand, using a multi-modal delivery methodology that includes in-person instruction, online courses, tailored webinars, and written materials. Following each provider training, our provider relations staff seeks feedback to understand the most valuable parts of the training, identify opportunities for improvement, and refine future curriculum.

Our enhanced provider experience model assures every provider has a dedicated Provider Experience Representative responsible for working with them to understand their needs and assuring our curriculum meets those needs. They deliver individual and on-site training sessions upon request or whenever a need is identified. Options include remote assistance through screen share, group presentations, webinars, workshops, and training at the provider's location.



Report Generation and Transmission

Because the need for reports and data extracts is dynamic, we rely on several resources to support reporting needs. These include local health plan leadership, Contract Compliance Officer and Quality Improvement teams, designated members of the national Regulatory Reporting Center of Expertise and Enterprise Reporting teams, and our Health Care Analytics and HEDIS® teams. This allows us to leverage team member skills and experience, share best practices, report logic used in other markets, and shift resources, as necessary.

We have industry-leading software and tools for data access, analysis, and report development to meet Nebraska demands. We believe team members need “the right tool for the right job.” To that end, we make a variety of tools available to accommodate and support a wide range of skills. Some tools support end-user query, data manipulation, and analysis, while others require more advanced skill levels. Examples of tools we use to create reports for internal management and submission to MLTC include SQL Server Management Studio, Business Intelligence Development Studio, Tableau, Online Analytical Processing Cubes, and Teradata SQL. Our report and data-generation process varies, based on type of submission:

- **Reports.** Reports include operational data from a current date and any additional data elements requested. Some reports may include narrative input. The business owner reviews the report and adds text as necessary to provide explanation or additional information.
- **Extracts.** A system job scheduler generates data, such as extracts for detailed provider information files. The process includes status, results, and error logs. We monitor regularly to confirm correct job execution and consistent results, such as accuracy of record count and encounter transaction formats. Formal automated notification alerts business owners that data is ready for review.

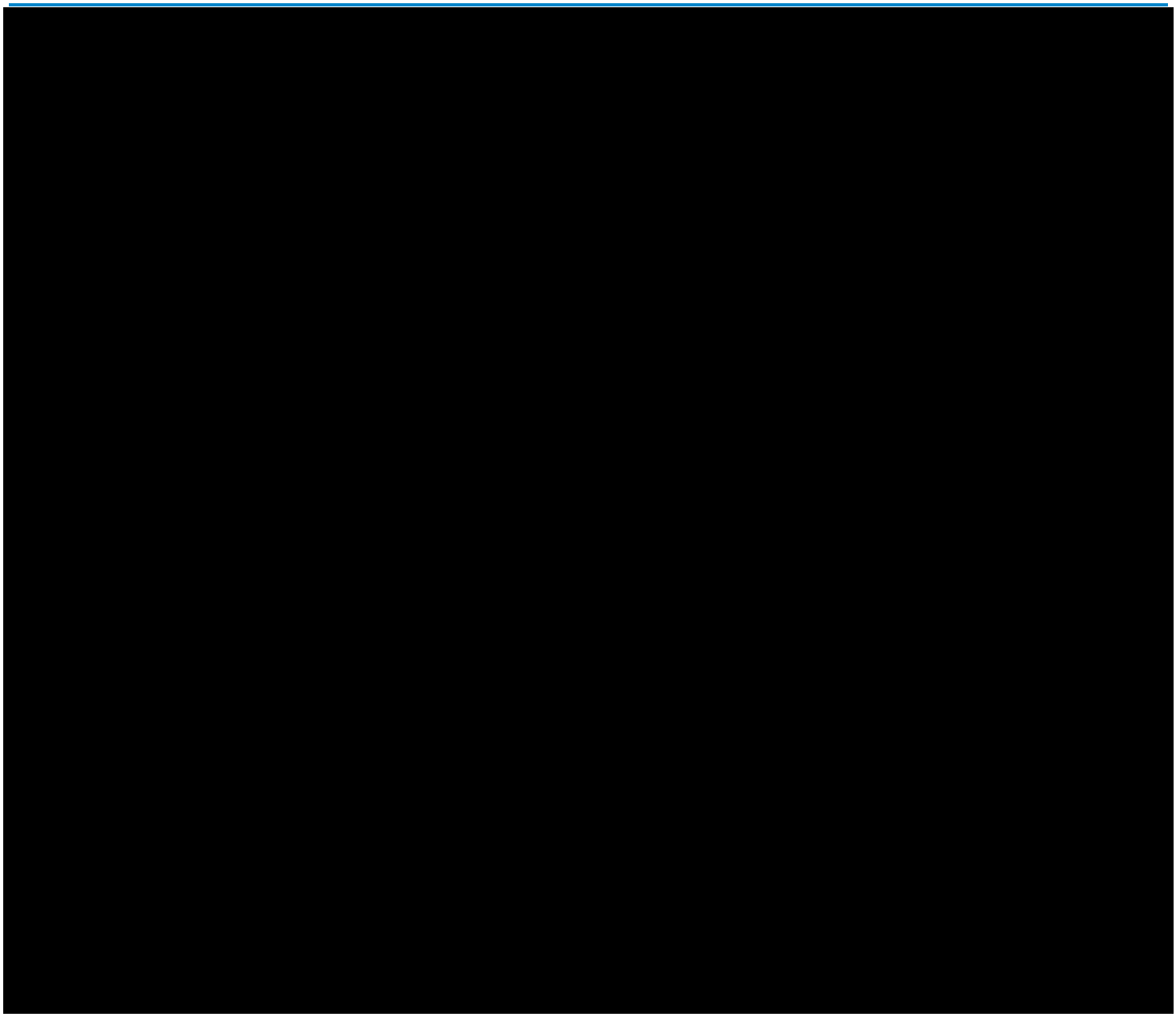
Our process includes checkpoints to confirm that all plans, reports, and data extracts are accurate and meet requirements before submission to MLTC, as shown in Diagram V.R.98-4. Compliance with our regulatory requirements is an essential part of our company’s culture, and we work continuously to meet the State’s expectations and requirements. Healthy Blue’s quality process means that all plans, reports, and data extracts are reviewed and verified by business process owners and the Regulatory Reporting Center of Excellence (COE) and senior leadership before we submit them to the State. After we submit each plan, report, or data file, the Regulatory Reporting COE updates the database to indicate the report has been submitted, along with the date of submission. The database automatically generates the due date for the next monthly, quarterly, or annual report. The database automatically generates the due date for the next monthly, quarterly, or annual report. Our reporting process and structure of quality control has advanced the accuracy and timeliness of our ongoing and additional reports, along with the date of submission.

Our health information system is built on a managed care model to support the collection, analysis, integration, and reporting of clinical record information and authorization and claims payment data in accordance with 42 CFR § 438.242. Our system's flexible design supports all MLTC requirements and can be easily adapted to support new and emerging MLTC and CMS reporting requirements.

Performance Reporting. We use integrated information from our health information system, including member eligibility, utilization history, grievance and appeals data, and provider attribution, to monitor quality and generate reports required by performance indicators. We monitor ongoing quality methods, including Healthy Blue's HEDIS metrics, annual reviews and evaluations, grievances and appeals, and targeted record reviews.

Ad Hoc Reporting. Healthy Blue's tools and protocols support delivery of accurate reporting and give us the capability to generate ad hoc reporting upon request from DHHS. Our reporting capabilities include:

- A health information system that collects, captures, and maintains the comprehensive data necessary for report generation and analysis
- Data accuracy through consistent edits on incoming data and carefully monitored processing
- A report-tracking system that documents all report due dates and responsible business owners



Quality

Healthy Blue's comprehensive Information Systems and data infrastructure drives consistent, timely, evidence-based decision-making and high-quality member outcomes. Our proprietary internal interactive analytic insights platform and HEDIS data mart systematically and objectively measure access to care and demand for services. Both use data from the data warehouse and other ancillary systems, as shown in Diagram V.R.98-5. We use these tools and systems to:

- Identify gaps in care to support member outreach and education
- Provide trends by HEDIS measure and track disparities across groups, twice monthly
- Support provider profiling and quality payment incentive activities
- Visualize patterns in quality results by region, county, and ZIP code
- Identify specific communities to target intensive interventions

Our data warehouse uses SQL Server and supports operational processes, advanced analytics and data modeling, quality management and improvement, and reporting. Fed directly from the system of record to promote data quality, control, and consistency, the data warehouse delivers a comprehensive source of health information about members and includes encounter claims data for the medical, BH, pharmacy, and dental services they receive. We integrate additional information into the data warehouse to support utilization, case management, and other processes, including lab results, immunizations, prescriptions, and other clinical data.

To foster continuity of care and reduce duplication of services and waste, we collaborate with our providers and share data through reports and a secure provider portal. The type of provider drives the amount of reporting and access we offer, with PCPs prioritized for information sharing. Through the provider portal, providers have access to an array of data and resources, including reports that allow them to view their success at meeting certain quality measures, such as a HEDIS Quality Measurement Report Card which compares current performance to national benchmarks and facilitates improvement discussions with provider groups. Providers participating in our Category 3 value-based purchasing (VBP) models have access to an array of performance monitoring and reporting solutions, including:

- **Provider Portal and Provider Care Management System (PCMS).** Providers can view actionable, member-specific information structured to enable them to examine current performance, identify opportunities for improvement, and develop action plans, processes, and workflows to improve quality and cost outcomes. Data includes enrollment, claims and encounters, authorizations, and provider and member satisfaction surveys and are available through both the Availity and PCMS portals.
- **Financial Recovery Group's Medical Economics Platform.** AccuReports® presents information from multiple sources in a crisp, drillable format (such as top-10 utilizers), with customizable dashboard graphs, enabling users to quickly spot trends, understand drivers, and act on opportunities to improve financial performance. Reporting includes comparisons to peers and benchmarks.
- **Tableau Provider Insights.** This tool includes detailed population health metrics, relevant utilization patterns, HEDIS results, and pertinent total cost of care metrics. Updated monthly, included reports provide comparisons to peers and benchmarks. The Tableau Provider Insights model offers three categories of reports:
  - **Total Cost Analysis (TCA).** One of the most popular reports, TCA provides a comparison of the provider's performance to that of Nebraska providers as a whole and providers contracting with our affiliate health plans across the country.
  - **Cost and Utilization Report.** Analyzes provider group utilization metrics across various service settings over time so that providers can understand where members receive their care.
  - **Population Health Management Dashboard.** Takes data from PCMS and displays it visually, enabling providers to explore member information, including demographics, cost of care, risk drivers, and chronic conditions.

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Care Coordination

Healthy Blue's fully integrated care management (coordination) platform, Health Intech, shown in Diagram V.R.98-6, is the system of record for member care management information. Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and Disease Management, is readily available in an organized format. Health Intech serves as our primary method for sharing member care management information, including health needs assessment screenings and care plans.

This system fully integrates with our CSP for member, provider, and claims data, and gives "life" to Healthy Blue AI that enhances member experience. It provides tools for Care Coordinators, Care Managers, UM Clinicians, and other Healthy Blue functional teams, such as our Provider Services and Quality teams. It seamlessly manages members' needs and coordinates as needed to provide an individualized care experience.

Member 360°. Our clinical data dashboard provides a holistic view of each member's utilization, care management services, and gaps in care to the Healthy Blue care team. We integrate data and information from multiple sources, including claims history, authorizations, ED visits, hospitalizations, immunization records, prescriptions, lab results, and data from health information exchanges (HIEs) and electronic health records (EHRs). Access to the same information facilitates collaborative care team meetings and better member outcomes.

Patient 360°. Providers use their secure website and Patient 360º to view member records, giving them simple, easy-to-access data and information to help them engage members in their health and well-being. Integrated data is displayed in near real-time to make it easy for providers to act on it, fill gaps in care, and make sure their patients are getting the services they need. This view enables any medical provider who is treating our members to see the full picture, including patient-centered care plans and assessment information, enhancing their ability to reduce redundant efforts and improve the quality of care. BH data has an added layer of security and confidentiality requiring "need-to-know" approval. Non-physical or BH providers (such as transportation, housing, or community providers) do not have access to members' confidential medical or behavioral information without prior approval. Through our secure platform, we strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access.

Our Health Intech platform delivers the following benefits:

- The availability of the provider view generates communication among the interdisciplinary teams (IDTs), including providers, so that conversations regarding member care coordination and outcomes easily occur.
- Our platform helps providers achieve the quality incentives defined in Healthy Blue quality programs. For example, a provider can look up the most recent HgA1c results for each of their Healthy Blue members with diabetes. The tool helps providers deliver care by not only providing relevant data related to each member but also generating prompts displayed in a succinct view to create actionable items at a glance.

Because access, use, or disclosure of information related to sensitive medical services is strictly limited by federal and State laws, information related to BH or other sensitive services may only be accessed through Health Intech with the authorization of the member or for BH treatment purposes. Healthy Blue extends the reach and collaboration of stakeholders involved in members' care and services. Our collaborative platform makes it possible to share information with all authorized members of the IDT. IDT participants are able to review and contribute to the plan of service, as authorized by the member.

Electronic Health Records and Health Information Exchange. Healthy Blue uses Epic's® Payer Platform to enable data exchange between a provider's electronic medical record (EMR) and Healthy Blue's longitudinal patient record. This includes prior authorizations, member insights, and clinical and claims data exchange. Healthy Blue and Epic are advancing interoperability to promote open communication and information transparency that gives members and providers integrated, real-time access to members' medical history, health insights, and treatment options. We are also working with EHR vendors, including Allscripts®, eClinicalWorks®, and athenahealth®, as well as third-party integrators to complete our members patient record. We are currently exchanging data with CyncHealth on ADT, ED utilization, member demographics, lab results, and clinical services files.

Setting of Care Assessments, Determination, Tracking, and Communicating. Health Intech integrates and shares pertinent member information, as applicable, with MLTC, Healthy Blue staff, and providers. The system aggregates member data from all available sources, creating a single personal health record (PHR). The PHR provides a complete and holistic summary of an individual's medical history, service utilization, and care plan to all team members and helps members engage in their health care. Improved data sharing leads to identification of gaps in care, improved continuity, and reduction in care duplication or fragmentation. Health Intech is fully compliant with all applicable State and federal laws, including HIPAA and the HITECH Act, and supports role-based access to essential information and functionality. Our consolidated PHR supports longitudinal, population-based reporting, which we use to evaluate care and optimize service delivery. Health Intech includes available data from the following:

- Healthy Blue's care management and claims processing systems
- Public health systems
- Continuity of care data (claims history or other information from MLTC or other MCOs)
- Other payers and providers (pharmacy, lab, diagnostic, and EMR data)

Health Intech provides full visibility of the entire member record for all physical health, BH, pharmacy, clinical review, and care management activities, including SDOH-related services. We work with providers and other stakeholders to inform UM decision-making and coordinate care. UM staff, Medical Directors, and the Quality Management and Care Management teams collaborate to identify and address issues and gaps in care.

[redacted]

Claims Processing

Healthy Blue's claims processing system collects, processes, and stores data on all health services delivered (including physical health, BH, and medical supplies) using standard HCPCS, ICD-10-CM, and revenue codes. Our claims process, from claims intake through payment, includes controls that validate and account for all claims submitted, as shown in Diagram V.R.98-7.

Comprehensive Claims Edits. Our claims processing system supports comprehensive claim edits, including enhanced clinical edits and National Correct Coding Initiative (NCCI) edits. This checks each claim for codes subject to unbundling or medically unlikely edits, identifying codes that may be incompatible with these standards. We incorporate edits that support MLTC program requirements, including edits that verify timely, accurate, and complete encounter records. The system validates that required data elements are present and match allowable values. It verifies member eligibility, service coverage, required attachments, and prior authorization. Our system also has the following capabilities:

- Resolve discrepancies between billed versus authorized units and amounts, cutting back units or dollars, as appropriate
- Allow editing or suspension of individual lines on a multi-line claim — so providers can receive payment for service lines that pass all edits
- Track all edits posted to the claim from suspension through adjudication

Adjustments, Corrections, and Voids. The claim system assigns each claim a unique internal control number (ICN) to track progress from initial system entry to final adjudication. It can differentiate an adjusted claim from the previously adjudicated claim. The system maintains details for each claim transaction at the time it occurs and records date of receipt. The claims system tracks all changes or corrections in corresponding audit tables. We use the ICN to access claims and their attachments, as well as audit trail information within our system. We can generate trail reports to facilitate auditing of individual claim records as well as batch audits. For integrity purposes, the system keeps transaction logs (used for commit and rollback of transactions) and error logs (recording failed operations). All logs enable comprehensive system and user-activity reporting.

Our claims and financial systems support recouping payments for voided or adjusted claims, as well as processing manual or reissued checks. We handle settlements outside of the claims system and mark them so the claims process will not process payment. When applicable, we void or adjust claims to reflect identified provider overpayments, regardless of whether they have been recovered.

Verifying Claims Against Electronic Visit Verification (EVV) Data. We will work with the other awarded MCOs to procure a common EVV vendor and will use data gathered from the EVV data collection system to validate all claims during the claim adjudication process. We are experienced with integrating data from EVV vendors including enhanced functionality such as GPS check-in verification, member preferred scheduling, provider dashboard and direct billing, improved management of late and missed visits, and identification of overlapping visits for workers. We have a demonstrated track record of meeting or exceeding State and federal requirements for EVV set forth through Section 12006 of the Cures Act (42 USC§ 1396b(I)) over more than a decade across our affiliate health plans.

Subcontractor Claims Processing. Healthy Blue delegates claims processing for dental, pharmacy, vision, Non-Emergency Transportation, and BH services to our MLTC-approved subcontractors. We require all entities to which Healthy Blue delegates claim payment to comply with statutory claims processing and Nebraska Medicaid contract requirements, including timeframes for processing clean claims. When we delegate claims payment to subcontractors, Healthy Blue maintains the same commitment to quality as if we processed the claims in house. For this reason, we require that all entities to which we have delegated claims payments:

- Submit all adjudicated claims (encounter) data within a condensed timeframe to allow for review and consolidation with claims processed internally in Healthy Blue's CSP
- Submit monthly encounter data and claims processing performance metrics that demonstrate compliance with all Healthy Blue, State, and federal requirements

We run all subcontractor encounter files through HIPAA- and State-specific validation, rejecting files that do not pass these edits. We review subcontractor claims payment reports against submitted encounter data to verify completeness of the data received.

Healthy Blue sets clear expectations for subcontractors through our Enterprise Delegation Oversight and Management (EDOM) program. Prior to submitting the subcontractor to MLTC for approval, the EDOM team conducts a pre-delegation audit to verify each subcontractor's ability to provide contracted services. Throughout the term of service, we conduct regular audits to verify continued compliance with MLTC contract requirements. Subject matter experts follow a standard quarterly audit schedule or complete one more often as needed. Auditors use tools that include mechanisms for reporting and ongoing review of data.

Claim Payment Disputes. While we focus on preventing issues before they affect claim payment, we maintain a robust provider dispute process available to all providers when they believe we have incorrectly processed their claim. See Diagram V.R.98-9 for more detail. Our claims dispute process is the same for in-network and out-of-network providers. We provide detailed information on our claims dispute process in our Provider Policy and Procedure Handbook, posted on the public pages of our provider website. Our remittance advice is available to providers electronically and on paper and includes instructions on how to file a claims dispute within the designated timeframe. Our provider claims payment dispute process offers a "no wrong door" policy with many ways to voice a concern or file a dispute, as well as multiple levels of review to resolve the issue, including:

- **Level One: Claim Payment Dispute.** Providers may file a dispute via phone, email, through Availity on the provider website, in writing, or verbally during visits with our Provider Relations team. Regardless of method of receipt or provider contracted status, we log the dispute in a central system and quickly route it to the team most capable of resolving the issue. The Operations team tracks disputes to make sure they are resolved appropriately and within the required 30-day turnaround time.
- **Level Two: Claim Payment Appeal.** Healthy Blue offers providers who are unsatisfied with their dispute outcome an opportunity to appeal the decision. Providers must submit appeals in writing (via mail or through Availity). In the same manner as the dispute, we log appeals in a central location and forward to the most appropriate team. To make sure the appeal is reevaluated equitably, assigned team members are more experienced than those who handle claims payment disputes. The Claims Administrator tracks resolution to the required 30-day turnaround time and monitors appeal timeliness and accuracy.

[redacted]

Grievances and Appeals

The Healthy Blue member Grievance System, which manages processes for member grievances, appeals, and State Fair Hearings, complies with federal and State regulations and operates based on the definitions and requirements in SOW.V.H. Our Grievance and Appeals team maintains and implements a patient-centered approach to resolving member grievances and appeals and helps assure that members have access to expedited review processes, external reviews, and the State Fair Hearing system. We maintain and update our written policies and procedures we use for our Grievance System, reviewing them at least annually or based on need. We complete all our grievance processes and activities internally and do not subcontract out any of these services. Our team is available to members whenever they have questions or need support filing a grievance or appeal. Our Member Services Representatives (MSRs) can help members file a grievance or appeal and can provide updates. We do not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Our Grievance System is shown in Diagram V.R.98-8.

We have built visualization tools and metrics dashboards for grievance analytics. This data is categorized using reasons for grievances, sources of the grievance or appeal, and timelines of response and resolution. The analytics tools are updated daily where appropriate to assure we have a current view into the inventory. Further analysis using grievances and appeals data includes monthly turnaround reporting, weekly and monthly volume trends, and deep-dive analysis to identify root cause.

We will link our Grievance System to our quality improvement (QI) plan and program evaluation that includes an analysis of grievances and appeals to inform continuous QI activities. We will track and trend grievance data by type and appeal data by service type. We will review grievance trends at the Quality Assessment and Performance Improvement Committee (QAPIC) to identify trends and discuss proactive solutions to improve processes and reduce the overall volume of grievances. Grievances related to quality of care will be fully investigated and referred to our Credentialing department and Clinical Advisory Committee, as appropriate. If a member filing a grievance is determined to have a care management issue or an assigned Care Manager, the Care Management team will be notified and engaged as needed to resolve the member's issue.

We will review grievance and appeal data by categories such as type of care and volume. A dedicated team of risk analysts within the Grievance and Appeals team will continuously mine data and monitor these trends weekly to be proactive in addressing members' concerns and contribute to programmatic continuous QI efforts.

These reports and analyses will also be presented to QAPIC on a bi-annual basis to discuss solutions to facilitate access to clinically necessary care, reduce any unnecessary burden on providers, and reduce the overall volume of appeals.

Analysis of member grievance data has led to focused interventions to improve transportation services for our Nebraska members. In response to a pattern of transportation-related grievances, Healthy Blue worked with IntelliRide, our transportation vendor, through weekly and monthly calls. We provided support and education to improve customer service and resolve the source of member grievances. These efforts resulted in improving the rate of successful transportation for members.

We recognize and appreciate the importance of a responsive Grievance System. In 2021, Healthy Blue implemented Smart Intake as an innovative solution that delivers increased efficiency in mailed and faxed complaints, grievances, and appeals by:

- Routing grievances and appeals to the correct area faster to accelerate resolution
- Clear identification of the type of communication coming through multiple channels
- Automatic case creation in our Grievance System
- Automated, “intelligent” triaging done in our Grievance and Appeals department

With the help of our Smart Intake system, Healthy Blue will resolve regular appeals within 30 days of receipt (72 hours for expedited appeals). Our Smart Intake system helps us acknowledge appeals within three business days. Our enrollment member grievance log documents our understanding of these performance standards. ***After the Smart Intake of mail in July 2021, 60% of grievances filed through the mail were automatically loaded into our systems.*** The October 2021 implementation of Smart Intake for our fax lines decreased the manual intervention needed by a staff member.

[redacted]

Claims Adjudication, Payment, and Coordination of Benefits for Claims with Third-Party Liability and Medicare

Healthy Blue's claims processing system uses automated workflows to manage the steps required to auto-adjudicate a claim. Auto-adjudication leads to faster and more accurate provider payment and supports complete and accurate encounters reporting. We quickly capture and adjudicate claims with minimum manual intervention by combining our core claims transaction platform with electronic document imaging and a workflow management system that includes an integrated rules engine. Our process includes initial HIPAA compliance and completeness validation and validation software that automatically and comprehensively audits codes before each claim is paid.

Claims Payment and Prompt Payment Guidelines. We configure our claims adjudication system to support the high standards established by MLTC. This same claim system supports affiliate Medicaid health plans in 23 markets and processed more than 1.4 million Nebraska Medicaid claims in 2021, maintaining an average turnaround time for claims payment of seven days and paying 95.5% of all claims in 30 days. Our claims processing system supports prompt payment, using automated workflows to manage the steps required to auto-adjudicate a claim. This maximizes speed and efficiency of the claims process.

A claim moves automatically through the system based on status at points in the process, minimizing manual work. When manual intervention is required, workflows automatically route claims to queues and analysts skilled in addressing the specific edit. There are several checkpoints with service-level agreement reporting throughout the claims workflow to provide insight into process timeliness. The system sends immediate feedback on EDI claims that have successfully loaded into the CSP and can track claim movement from adjudication to payment through reporting and workflow queues.

On a quarterly basis and according to timelines established by MLTC, we submit quarterly prompt pay reports. We measure and comply with prompt payment standards by claim types and pay or deny all submitted clean claims for both in- and out-of-network providers — 90% within 30 calendar days of receipt and 99% within 90 calendar days of receipt.

Coordination of Benefits (COB) with Third-Party Liability (TPL). We actively seek and identify third-party resources, including Medicare coverage, other health insurance (OHI) coverage, and other liable third parties. We identify Medicare and OHI coverage through multiple avenues, including:

- Providers indicating this information on or with claims submissions
- Vendor partnerships for acquisition of Medicare and OHI information
- Claims data-mining processes performed on all inbound claims
- Daily Medicare, OHI, and TPL leads received throughout the company from members, providers, and internal member services and care coordination staff

We store verified TPL and OHI information in each member's electronic record within the CSP and submit all potential OHI leads to the Cost Containment Unit (CCU) for validation. This team conducts daily reviews of all OHI and TPL leads received throughout the company from members, providers, and other sources. The CCU validates OHI and TPL information with the primary carrier; and, if appropriate, adds to the member's record on a COB tab. All available data regarding alternate insurance is stored in the member's electronic record, including policy number, policy holder's name, group policy name and number, member's relationship to policy holder (including non-custodial parent flag), and insurance coverage dates.

Integrating Cost Avoidance with Claims Adjudication. Healthy Blue's claims processing system is fully integrated with our TPL process to capture OHI information contained on the claim and evaluate OHI information stored in the member's electronic record. Our claims process effectively supports cost avoidance by automatically applying edits during adjudication to identify potential overpayments, based on current alternate insurance information on file. We provide MLTC with TPL information weekly, including a change file based on reconciliation with MLTC's data. We provide process-flow diagrams for COB and TPL processes in Diagram V.R.98-9.

Systems Modules to Track and Administer Different Medicaid Benefit Packages, Copays, and Premiums

Our CSP supports the administration of Medicaid benefit packages, copayments, and premiums and consistently demonstrates the capacity to maintain, provide, and document information to support continued contract compliance. We understand the importance of maximizing resources available to members, preventing duplication of services, and complementing services provided through other funding sources and programs. Our CSP delineates between funding sources for which a member may be eligible, such as Medicaid, non-Medicaid, state-only, or block-grant funded.

Benefit Packages. Healthy Blue adds or updates member demographic and eligibility information using data from daily and monthly 834 files and monthly 820 capitation files. We maintain complete eligibility history for all members to manage variation in benefit category and product — maintaining a complete timeline of participation in the Nebraska Heritage Health program. Healthy Blue configures and tests our member eligibility and claims systems to reflect the appropriate benefit package for members, including the effective date of the change. When MLTC requires a change to a benefit payment, we can implement a minor change within 30 days. When implementing a minor change to a benefit payment, we make necessary modifications to production environments and update our authorization and benefit system configuration, claims edits, encounter data submission, reporting, communication, and training.

Copayments. In states where our affiliates collect copayments, they receive family income data via the 834 file from the State and track copayments, member debt, and other cost-sharing information against income. Our finance and accounting system tracks services across funding streams using our general ledger and accounts payable systems.

Premiums. We receive and process capitation data via monthly 820 files. We load the capitation data into our Electronic Premium Analysis System (ePAS) to reconcile Medicaid membership and capitation payments. Our Premium Reconciliation team reconciles the monthly capitation and premium billing files received from the State. Using ePAS, we compare the 820 premium payment transaction file from the State against our member data in our CSP.

[redacted]

Encounter Reporting

We base our claim and encounter edits on MLTC program requirements and provide MLTC with the information to perform rate setting, QI monitoring, contract compliance, and utilization analysis. If a claim or encounter fails one or more edits, we route it for triage and correction so it can be resubmitted.

We collect data on all services furnished to Nebraska Medicaid members. We report these as encounter data to MLTC following the 837 post-adjudicated claims data reporting standards for encounter data submissions. As shown in Diagram V.R.98-10, our encounter data process combines all claims and adjustment data processed since last submission, including claim data from subcontractors, and loads it into our Edifecs system. Controls validate that CSP and subcontractor claim records load properly for processing. The Encounter Data Quality Coordinator oversees the entire encounter process lifecycle, from data collection to the creation of an encounter submission, through acceptance of encounter data, and receipt of encounter status. Our system maintains comprehensive information on each encounter record in a submission batch. This allows us to monitor submission and revision and track trends over time that may identify issues or opportunities for improvement.

The Encounter Data Quality Coordinator uses a series of internal reconciliation and certification reports to manage, monitor, and validate integrity of encounter data submission. They work closely with the Encounters team to resolve problems quickly. The Encounters Manager uses self-service reporting tools to measure performance and track trends. These fully automated tools identify variances in financial completeness, accuracy, and timeliness. They offer drill-down capability to the claim level, which accelerates research for root cause analysis. We refresh data in these tools at least weekly. When we identify errors or conflicts for a previously adjudicated encounter or claim, our encounter remediation process supports adjusting or voiding the encounter within the timeline specified by MLTC. We follow a comprehensive schedule of system processes, review tasks and submission dates, and employ several checkpoints during our process. This oversight prevents encounter data submission problems, including:

- Logging details of each submission and capturing source claim information, such as claim number, type (original, adjustment, void), file name, path, and creation date
- Checking for and removing duplicate records
- Reconciling queued encounter data to claims processed for eligible services during the matching time period (including paid, denied, and voided claims)
- Applying edits, including checking for member eligibility, MCO enrollment, valid CPT codes, and cross-field editing
- Verifying compliance with MLTC's Encounter Data Companion Guides and the X12 Implementation Guides for X12 transactions

We submit encounters for all claim activities, including adjustments at the individual line level or in a mass adjustment update. Submitted encounters accurately reflect final status of adjudication as reported to the provider, including denial, with valid line-level detail, meaningful claim adjustment reason codes, and remittance advice remark codes.

Claims Submitted via Secure File Transfer Protocol Every Wednesday

We process encounters weekly and submit via SFTP no later than 2:30 p.m. CT. These include:

- Complete batch encounter data for all adjudicated claims for paid and denied institutional, pharmacy, and professional claims
- Any claims not submitted previously

We understand that MLTC uses an overall average of calendar month submissions to assess compliance with encounter claim submission requirements.

Auditing and Validating Encounter Data Submission

Data Verification. To support clean encounter data, we apply front-end edits on claims in accordance with MLTC requirements. This results in the pending of claims that need to be reviewed and worked by market analysts, health plan claims teams, or other support teams, to be resolved, corrected, and submitted.

Data Accuracy. We leverage proven systems, controls, operational processes, and experience to guard against fraud, waste, and abuse (FWA). By combining the local expertise of our health plan employees with our proven national processes and resources, our Program Integrity (PI) organization employs a variety of tools and processes to make sure services delivered to eligible members are effective, efficient, and rendered — with associated payments made — by legitimate providers. As a part of Healthy Blue's PI organization, the Special Investigation Unit (SIU) closely monitors claims to make sure providers are not billing for services that are not rendered.

Collecting Complete Data. Our weekly encounter process retrieves claims records for every service rendered to a member for which Healthy Blue either paid or denied reimbursement. We base our claim and encounter edits on MLTC program requirements and provide MLTC with the information they need to perform rate setting, QI monitoring, contract compliance, and utilization analysis. If a claim or encounter fails one or more edits, we return it to the submitter for correction and resubmission.

The encounter collection process selects newly adjudicated, voided, and adjusted claims processed since the last submission and loads the data into our encounter staging area. The number of claims is verified against the source data. If counts do not match, we identify the encounters causing the gap, resolve the issue, and rerun the process.

Financial Management and Accounting Activities

Our CSP supports financial functions required for managed care service delivery, including tracking all financial transactions by program, source, and fiscal year. This verifies appropriate disbursement of funds for claim payments and accurate application of all post-payment transactions. We maintain all data required to support financial reporting functions, as well as controls to track all financial functions, including batch balancing, audit trails, and claims history. Diagram V.R.98-11 details Healthy Blue's financial processes.

Healthy Blue provides detailed completeness reports for financial reporting purposes to make sure we are tracking overall encounter performance and quality. We know and understand the encounter logic required to execute on properly submitted encounters. Healthy Blue has requirements in place to confirm we have the correct information on members to load a member record and to make a provider eligible to be paid. These requirements are built and driven by the requirements of an encounter; as a result, we do not allow a claim to adjudicate if we will not be able to submit a corresponding encounter.

Healthy Blue understands the importance of the collection and reporting of complete and accurate encounter data that details all the services provided to members. We use five key mechanisms to help assure completeness and accuracy of encounter data.

1. Front-end HIPAA compliance validation checks are performed upon receipt of EDI claims files from providers within Healthy Blue's EDI gateway. This level of validation confirms data is syntactically and structurally correct and sound.
2. Claims data validation and business rule edits are applied once claims pass all EDI validation edits and are loaded to Healthy Blue's Facets claims system. Such edits may include member eligibility edits, provider data related edits such as presence of valid NPI, service code edits such as validation of procedure, and revenue codes, among others.
3. State-specific encounter rules and data quality validation helps assure all the data required for encounter submission is present and valid on the outbound encounter record. This may include the presence of NDCs when required, presence of various billing.
4. Rendering and attending provider data elements such as NPI, taxonomy, and presence; data structure; and validity of other key data elements required for State encounter reporting. We correct any errors detected before releasing the encounter for submission to the State.
5. Submitted encounters are loaded to our encounter processing system for submission only when the claim is fully adjudicated and finalized to a paid and/or denied status. Thus, all submitted encounters have a corresponding claim.

Healthy Blue uses dashboards to oversee completeness, accuracy, and timeliness for all encounters. In the event an encounter is not accepted at the State, we maintain processes for root cause analysis and remediation to improve overall performance.

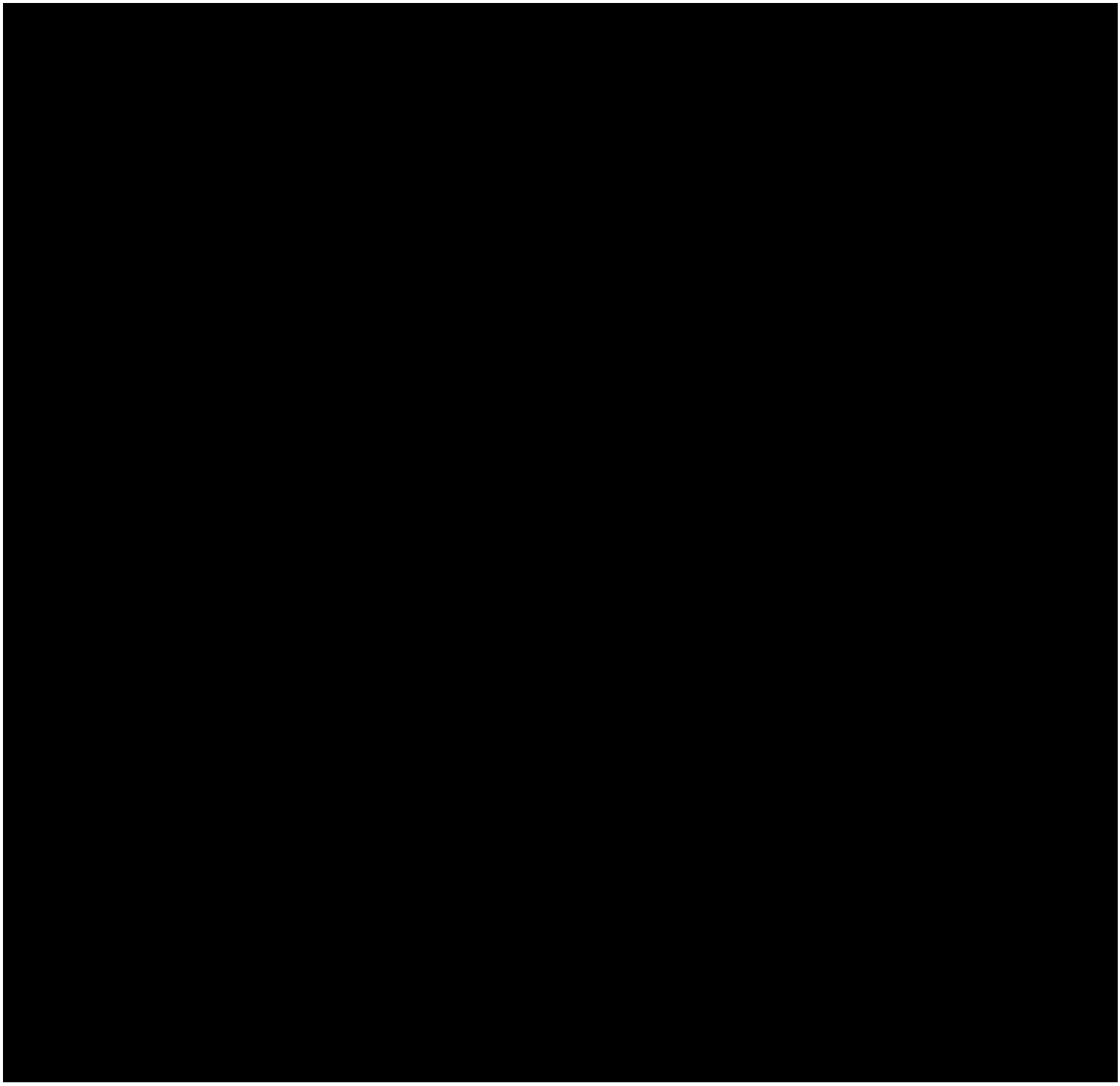
Using an enterprise financial reconciliation tool, we compare financial claims data to accepted encounters. If there is a discrepancy between the financial claims data and accepted encounters, we use Tableau tools to drill down to the claim level for both pended and rejected encounters. Healthy Blue has regular cross-functional meetings to review encounter data issues and take action on corrections.

No. 99

Information Security Standards

[redacted]

[redacted]



No. 100

Assuring System Availability

Our Technology Services team supports the continuous operation of Healthy Blue's health information system, including network security, compliance, computer and application support, system configuration, program development, and data warehouse. [redacted]

IT Enterprise Service Desk. The IT Enterprise Service Desk is the single point of contact (SPOC) for all incidents related to information systems for employees and contractors of our organization. Service desk staff use a specialized help desk system to track issues from receipt through resolution. This end-to-end help desk system provides enhanced communication tools, enabling users to send issues, questions, and documentation between teams to quickly resolve issues.

[redacted]

[redacted]

- Monitoring network devices, circuits, websites, and application transactions
- Communicating outages within IT and to impacted business/functional areas
- Facilitating and resolving all P1, P2, and P3 outages
- Approving emergency change requests

[redacted]

No. 101

As a current incumbent MCO, Healthy Blue has a robust and reliable eligibility and enrollment database that reflects the State's eligibility and enrollment data, supports the identification of members across multiple populations and systems, and supports the identification and resolution of any discrepancies between our system and the State's. Healthy Blue has extensive experience, well-established eligibility and enrollment processes, and systems that meet the current MLTC requirements for Nebraska Heritage Health. Through these successful processes and systems, we will continue to process member eligibility files and reconcile monthly eligibility data for Nebraska Heritage Health.

Our Core Service Platform (CSP) is the system of record for all member data, including current and historical demographic and eligibility information. We control updates via role-based password access to the user interface or application-specific data loads, such as MLTC's 834 enrollment files, and maintain an audit trail of all changes made to each member record. In 2021, we processed 981,370 transactions on 834 files with 99.8% auto adjudicating no later than the next day. All of the remaining transactions were addressed and completed within 48 hours. Healthy Blue currently exceeds the State requirement to load eligibility information into our claims system within five calendar days of receipt by loading more than 99% within one day. Our enrollment management processes are described in Figure V.R.101-1.

Enrollment Load Process

We have established a comprehensive enrollment load process that adds or updates member demographics and eligibility information using data from the daily and monthly X12 834 files, as well as monthly X12 820 capitation files received from MLTC's Medicaid Management Information System vendor. This is completed within 24 hours of receipt of the file via a secure transfer method. We maintain complete eligibility history for all members, using uniquely dated spans to manage variation in each individual's benefit category and product — maintaining a complete timeline of participation in the Nebraska Heritage Health. We also download and process additional files that supplement the 834 and 820 data, including PCP Assignment and History files and the monthly Level of Care and Retro Reconciliation Report.

As we are notified of new members through receipt of the 834 files, Healthy Blue assigns each a unique ID to track and manage the individual throughout all systems within our span of control, including our relationship with subcontractors. This number stays with members even as they move between benefit plans and products. We track family relationships using information provided in the enrollment data, linking family members together to make it easier to coordinate their care, even in different Healthy Blue programs. As the system of record for member data, our CSP allows us to identify members across multiple populations and systems. Since the 834 files include data on which eligibility category each member is in, when our CSP receives a new 834 file from the State, we record the eligibility category and reconcile it with any past entries for that member.

Verifying and Reconciling All Member Data

For each eligible member, Healthy Blue verifies member eligibility data and reconciles it with capitation payments. Our Enrollment and Billing teams perform reconciliations for our member eligibility using the monthly 834 audit file to perform an audit reconciliation. Our Premium Reconciliation team reconciles the monthly capitation and premium billing files. Using our Electronic Premium Analysis System (ePAS), we compare the 820 premium payment transaction file from the State against our member data in our CSP. The process compares total capitation on the 820 file against total amount of premiums billed for members in our CSP. Additionally, a member-to-member comparison looks for:

- Members on the 820 file but not in our system
- Members in our system but not on the 820 file
- Members with data inconsistencies between the 820 file and our system, such as 834 capitation category not matching the 820 capitation category

Our Premium Reconciliation team leads the review and investigation of discrepancies and coordinates with others as necessary, including the Enrollment and Billing teams. If we can resolve the discrepancy, we update our system. If we cannot, we notify the State. Our reconciliation process identifies capitation over- and underpayments.

We work closely with the State to reconcile our records, including State recoupment of capitation overpayments. Healthy Blue tracks the results of each monthly reconciliation and logs any discrepancies. We document the total number of discrepancies by type and detail any required updates to member enrollment. Our Nebraska Medicaid finance team manages and monitors these processes.

Processing Records to Update Member Information

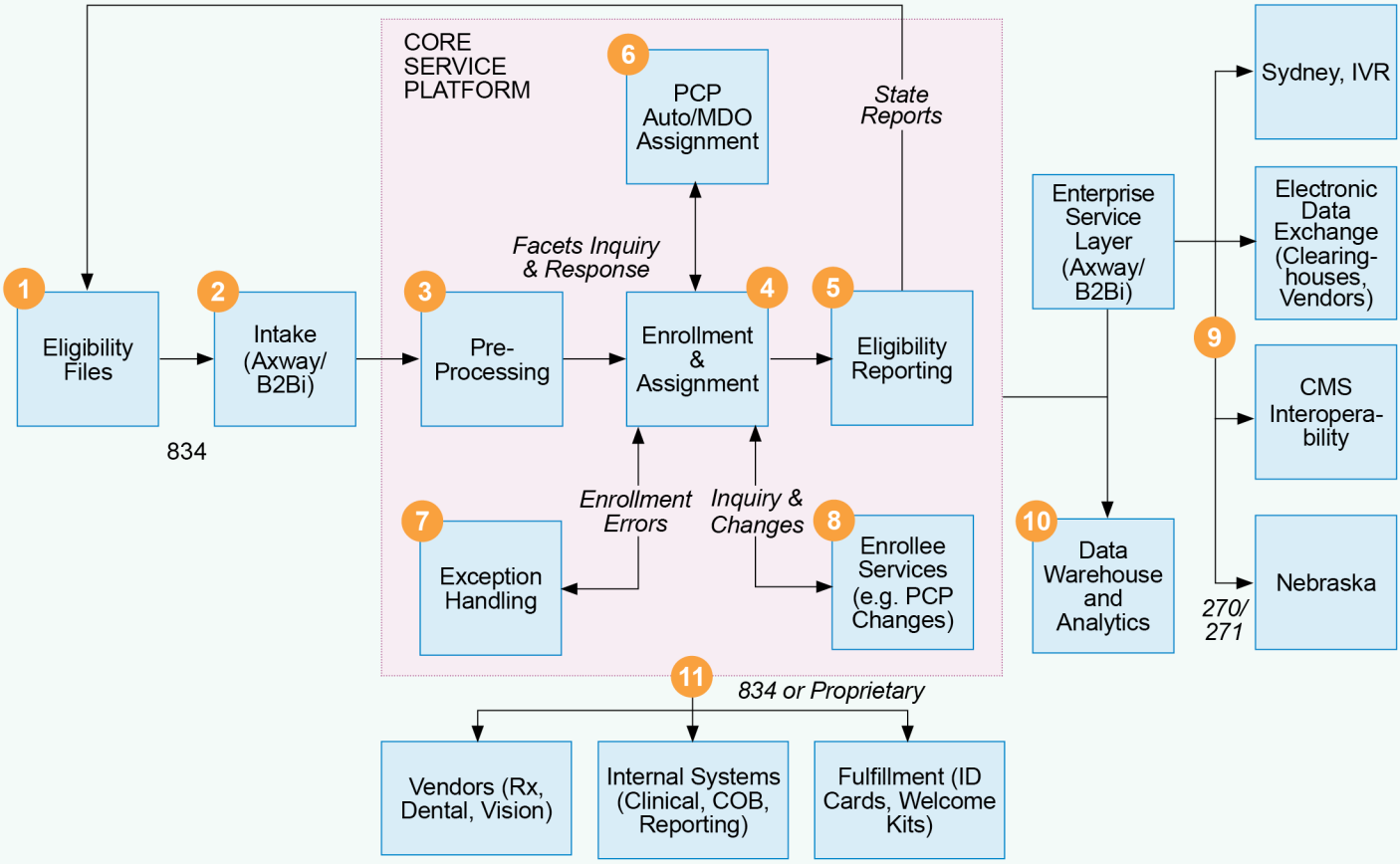
Healthy Blue receives and processes daily eligibility files containing data that is used to add, update, or terminate member information into our CSP. We also receive capitation data on the monthly 820 files. We load the capitation data into ePAS, a robust system developed internally by our technology support services team to reconcile Medicaid membership and capitation payments. Further, all files are run through HIPAA compliance validation before loading. Eligibility or capitation payment discrepancies are reported to MLTC within 30 calendar days of their discovery and no more than 90 calendar days after MLTC delivers the eligibility records.

Returning Capitation Overpayments Promptly

Healthy Blue returns any capitation overpayments to MLTC within 45 calendar days of discovering the discrepancy.

Figure V.R.101-1. Our Eligibility and Enrollment System Accurately Reflects State Enrollment Data.

Member Eligibility, Enrollment, Disenrollment



1. State sends the enrollment/disenrollment files to Healthy Blue
2. External Customer Gateway receives the files over a secure connection
3. 834 is validated for HIPAA compliance, business rules are applied, and a keyword file is generated
4. Our management information system process loads the member eligibility from the keyword file
5. Operations and state-specific reports are generated and distributed using Axway B2Bi
6. PCP assignment occurs based on business rules
7. Enrollment team corrects the errors and updates our system. Errors during the processing are captured and the Member Services team is notified for review
8. Member Services team reviews inquiries and updates CSP
9. Data is shared with our state partners and downstream systems such as 270/271 transactions, interactive voice response systems, portals, and mobile applications
10. Data is pulled from CSP and other sources for reporting and analytics.
11. Enrollment and eligibility updates are shared with downstream applications and vendors

NE_HH22_MemberEligEnrollDisenroll_Ver2_PFC_03

No. 102

Information Security Management

To protect data confidentiality, integrity, and availability, Healthy Blue employs a defense-in-depth security strategy that incorporates administrative, technical, and physical controls at the network, operating system, application, and data store levels. Our information security standards represent a comprehensive body of detailed security requirements consistent with industry best practices; standard frameworks, such as ISO 17799 and National Institute of Standards and Technology (NIST); and the regulatory requirements of HIPAA, the Gramm-Leach-Bliley Act, and the Sarbanes-Oxley Act. We use several industry-leading tools, such as Splunk, McAfee, and Symantec, in our environment for monitoring, logging, and implementing other data protection measures.

[redacted]

[redacted]

No. 103

Operational and System Redundancy and Back-Up Sites

[redacted]

[redacted]

[redacted]

No. 104

Claims Readiness

Healthy Blue will provide a seamless and efficient implementation of the new Medicaid contract and requirements. As an incumbent MCO with a long-standing presence in Nebraska, we have a robust understanding of the State, combined with an established and advanced foundation to meet member and community needs. We have proven capabilities and are well situated to execute quickly and flawlessly, starting from contract award through Go-Live and beyond. [redacted]

As an incumbent, our fully integrated team has been on the ground in Nebraska listening to and learning from members, providers, advocates, associations, and community-based organizations in urban, rural, and frontier areas. We understand MLTC's requirements and expectations for their MCO partners, and our Nebraska-based leadership team has executed on all current Scope of Work (SOW) and other regulatory and federal requirements throughout our tenure in the State. As the State works to implement this new contract, MLTC can count on us to remain a trusted partner in designing and implementing programs that address Nebraska's health priorities and improve health outcomes.

[redacted]

Our readiness to pay claims extends beyond just medical claims. For example, when testing our claims payment system, pharmacy claims get extra attention since that is where any potential problems associated with policy changes tend to appear 1st because pharmacy claims are paid at the point of sale. In addition, we have strong provisions in place to ensure that our subcontractors, such as our dental subcontractor Liberty Dental, have similarly robust systems and policies for paying claims, and rapidly and accurately adjusting to any policy changes.

Our experience, systems, and policies enable us to ensure a rapid response to any changes or issues.

Healthy Blue Will Meet All SOW Requirements and Continue to Serve Members and Communities on Day One

In developing our implementation plan, we will combine updated claims requirements from the SOW and include new initiatives that we have proposed within this response to produce a complete Requirements Matrix. We will review requirements, staffing structures, along with policies and processes that may need to be created or updated, and outline timeframes for readiness preparation and State review. To support ongoing, successful Nebraska programing, we will continue to leverage our experienced leadership and staff, existing community partnerships, and established provider network. We will focus on implementing new capabilities to meet the contract and test to assure we are ready to provide the best service on Day One.

Healthy Blue Project Management Leadership and Oversight

Our cross-functional implementation team works collaboratively to achieve successful implementation and manages resources and schedules to assure we manage risks and meet timelines. Our Nebraska operations team works closely with our national Implementation Management Office (IMO). The IMO is a dedicated team of certified project managers, focused on successful implementation of new health plans, programs, and contracts across Healthy Blue and our affiliates. In partnership with local Nebraska leaders in functional areas, the IMO will execute a comprehensive new SOW implementation approach that begins by preparing for readiness during proposal development and extends 90 days after Go-Live. Our local leadership and accountability approach for implementations fosters true collaboration and understanding of needs within the State and allows us to remain nimble and quickly identify and mitigate risks.

Strategy for Identifying Problem Areas

We have built our initial work plan to begin any necessary testing and informal Readiness Reviews well in advance of the SOW effective date. This allows for changes to the critical path without affecting our ultimate readiness. Vimal, the Implementation Manager, and the Nebraska leadership team will conduct regular check-in meetings with implementation leads to monitor progress on deliverables, identify issues that could affect implementation timeliness, and plan for resolution. The team tracks, reviews, and reports on dates critical to the State to keep all parties informed of progress throughout the project. Healthy Blue employs several strategies to mitigate risks, including:

- Establishing strong implementation and project management leads
- Using agile system development methodology to incorporate process flexibility
- Maintaining open channels of communication with MLTC and other stakeholders
- Fostering a "can-do" attitude within our team — doing whatever it takes in challenging situations to make things happen when we do not have additional time or resources

We leverage important lessons learned and innovations from our experience within Nebraska and affiliates in other states to make recommendations, determine best practices, and understand trends. As Nebraska's Medicaid program has grown in complexity over the years, we have been at the forefront of designing and implementing innovative solutions that increase access to care, improve quality and outcomes, and maximize cost-effectiveness. This experience gives us a strong foundation for continued innovation and best practices, so Nebraskans in all geographic locations can receive the very best care.

New Program Implementations

Our parent company has built a strong reputation based on an impeccable record of successful Medicaid implementations. In addition to our deep Nebraska experience, we bring lessons learned from affiliate implementations. This combination of experience benefits

Nebraskans as we continue to collaborate with local providers, associations, and community-based organizations to bring the right innovative offerings.

We have demonstrated our experience and capabilities to pass SOW Readiness Review using our proven implementation approach that ensures we are ready to process claims day one. We have never failed a Readiness Review or not gone live with a new program, population, and/or service.

Our national IMO has planned and executed more than 270 successful implementations across our corporate family. Our robust implementation process supports timely response to program changes initiated by the State.

Throughout our tenure in Nebraska, we have demonstrated partnership, commitment, and ability to meet State Readiness Review expectations. We have successfully participated in three Readiness Reviews for new contract implementations in Nebraska. Healthy Blue will devote the same attention, resources, and commitment to meeting Readiness Review requirements for this new SOW. We are well prepared to meet our existing SOW requirements and have begun preparing for yet another successful Readiness Review.

Implementation of SOW Changes and New Programs

As an incumbent MCO, we have proven our ability to serve Nebraska members and the State.

We have already begun the implementation process for new SOW and program changes. For example, our Call Center leadership team is actively working to implement the new member and provider service requirements identified in the new SOW. We have incorporated all new service level standards into our Nebraska staffing model to make sure we have the appropriate level of resources to execute successfully. Claims leadership will take similar actions when requirements are fully defined. We are ready to continue our successful track record for the new SOW, focusing on implementing all SOW changes and new programs and ensuring quality reporting data that is important to the State.

In addition to managing all SOW requirements and changes, our commitment to successful execution goes beyond the SOW and includes identifying and addressing changing MLTC priorities. For example, in 2020, we quickly implemented expanded telehealth offerings to meet the emerging needs of Nebraskans during the pandemic. Healthy Blue collaborated with MLTC and adapted to the relaxed federal and State policies extending telehealth capabilities. This includes Healthy Blue's LiveHealth Online (LHO), which provides members real-time access to Nebraska-licensed, board-certified physicians for urgent care consultations for clinically appropriate conditions, such as cold, flu, allergies, and other non-emergent conditions. Nearly one in five members indicated they would have gone to the emergency department if LHO had not been available. [redacted]

No. 105

Claims Processing

As an experienced and trusted partner to MLTC since 2017, Healthy Blue knows the importance of accurate claims and encounter data for effective management of clinical and health care services information. [redacted]

Paying providers accurately and promptly is vital to our mission of operational excellence. We are dedicated to streamlining the claims submission process and easing the administrative burden for all providers, both in and out-of-network. This dedication is demonstrated through our current best practices, such as offering multiple ways to submit a claim and running payment cycles six days per week.

[redacted]

Processing and Paying Claims

As an incumbent Nebraska Medicaid MCO, we have demonstrated our claims systems and processes are compliant with State and federal regulations. Our claims processing system uses automated workflows to auto-adjudicate claims, maximizing speed and accuracy. Healthy Blue's claims processes follow industry standards and are HIPAA-compliant with strong administrative, technical, and physical safeguards to maintain member privacy. We require submission of a complete and accurate claim for every service delivered to a member.

We show our full claims payment process including claims audits in Figure V.R.105-1.

Auditing Claims

All Nebraska Medicaid claims are part of the quality audit program maintained by our Program Integrity team to verify timeliness, accuracy, and integrity for all claims processed by Healthy Blue. Quality audits present a holistic view of the health of our claims processing systems and processes by verifying the financial and statistical accuracy of our paid claims.

To measure overall claims accuracy, each month Healthy Blue conducts end-to-end audits (from receipt of the claim to its final disposition) on statistically representative samples of Nebraska Medicaid claims to verify compliance with all federal, State, and internal requirements and provider contracts. All audits completed use source documentation to validate accurate claims payment. These sources include our State contract, coverage and benefits information, fee schedules, and provider contracts. Audit results drive feedback and process improvement initiatives.

Any audit resulting in a finding that a claim was not processed correctly is referred back to the department owning the issue. That department must review the finding and either dispute it or provide a corrective action plan that includes identifying other impacted claims and reprocessing them.

[redacted]

[redacted]

Claims Denial Management Taskforce. Timely review of denial rates and trends minimizes the volume of inappropriate claim denials and any undue administrative burden on providers.

Our Claims Denial Management Taskforce is one example of Healthy Blue's effort to ensure accuracy. This Taskforce monitors claim metrics around denials, focusing on trends and variances. As trends or outliers emerge, the team conducts a root cause analysis and promptly engages the appropriate stakeholders. This includes updating configuration or reaching out to providers to ensure proper billing techniques. Weekly, the Claims Denials Management Taskforce reviews trends for operational metrics, including:

- Top Denial Reasons (split by professional and institutional claim types)
- Denials by Procedure Code
- Top Providers by Denial Reason (critical when mitigating an issue or ensuring successful configuration)

Reduced Denials Create Efficiencies. Our efforts have resulted in substantial reduction in denials. Healthy Blue's denial rate has dropped significantly since April 2020, resulting in increased satisfaction on the part of our network providers.

The Claims Denials Management Taskforce has proven invaluable in proactively identifying and correcting inaccurate denials. This Taskforce works in tandem with our Provider Experience team to quickly reach out to providers who are practicing incorrect billing that

results in denials. Providers appreciate the education, helping them to get their claims paid without the need to file a dispute. When the team identifies a systemic issue with our own processes, we implement a fix, identify and reprocess affected claims, and alert the Provider Experience team to inform providers that a remedy is on the way. The Provider Experience team also leverages relationships with provider associations to quickly disseminate information on an issue or system fix that might be impacting a specific provider type.

Monitoring Claims Adjudication Accuracy

As a partner to MLTC in the Nebraska Medicaid Program, we have assembled a Claims team that blends decades of Nebraska-specific experience with the support of industry-leading Medicaid managed care experience. Through this collaboration, we have established formalized processes and tools to monitor claims operations, improve accuracy, and decrease risk. We have established a local Denials Management Taskforce and leverage our national Claims Review and Resolution Team (CRRT), Configuration Root Cause Team (CRCT) and Market Business Rules (MBR) team to identify configuration and process issues that have impacted claims processing accuracy. These teams are comprised of highly trained and experienced Claims Research Analysts focused on resolving complex provider claims issues who determine if a claim was paid appropriately based on the configuration of the system, including business rules, provider contract, plan benefits, and federal and State regulations. When a potential provider or system-level claims issue is identified, the information is routed to the appropriate department (such as pricing configuration or front-end claims editing) and it is tracked to resolution. [redacted]

We use established systems and tools to monitor KPIs — including claim aging, denials, and other trend data. Claim aging and denial reports are a standard part of our claim operations. Our Operations team monitors daily claims processing metrics using these reports and drills down to individual claim detail to identify and address issues that are slowing down claim processing or increasing denials.

Policies and Procedures for MLTC Updates

We have established policies and procedures regarding the maintenance of all data necessary to support our Nebraska Medicaid operations, including covered benefits, reimbursement rates, and fee schedules.

Our Compliance team supports continued adherence with MLTC requirements. Daily, this team monitors MLTC communications for amendments, bulletins, and other notifications, and utilizes our internal Compliance 360 application to send out alerts to relevant subject matter experts if an update is identified. Notifications concerning covered benefits, reimbursement rates, and fee schedules are sent to the Claims team. The Claims team then reviews the alert, determines impact to existing configuration and procedures, and assigns tasks to be completed to support the new requirement.

When a regulatory change impacts claims processing, the Claims team documents the necessary change, submits an intake form to the Configuration team, and develops and implements a testing strategy. The Claims team also coordinates appropriate communications within the required timeframes to providers and other partners that may be affected.

Healthy Blue has two specialized Configuration teams equipped to handle the nuances of the necessary change:

- Pricing configuration and fee schedule changes are completed by the Pricing Configuration Management (PCM) team with oversight from the Claims Compliance 360 team. Our PCM team is comprised of industry-leading coding and reimbursement experts who review changes from both MLTC and CMS, as well as updates to standard code sets.
- Changes that impact what or how a service is covered (such as benefit limits or copayments) are handled by our Benefit Configuration team. These skilled resources are experts on the benefits offered through Nebraska Medicaid, which is important for addressing the nuances between different aid categories and cost-sharing groups.

Updating Fee Schedules Within 30 Days of Effective Date or Date of Notice

All system changes are reviewed to determine impact to past claims, future claims, and those currently in our queues for processing. Once the change has been made, the relevant Configuration team reviews the results to verify the change is working as expected before the change is pushed to production. If the effective date for the change precedes the implementation date for that change, local Operations leadership and the Configuration team develop a work plan to reprocess any claims that meet the date of service requirements but were processed before the change implementation date. Timeline for fee schedule updates supports required 30-day turnaround time.

As a result of configuration process improvements, all 2021 monthly fee schedule pricing updates to date have been implemented in an average of 12 days or less. Implementation timelines for our benefits team vary based on the scope and complexity of the change request. Simple benefit or copayment adjustments can be made in comparable timelines as our fee schedule updates; however, more sweeping changes, such as building a new coverage type or completely overhauling how we cover a particular service, require longer implementation windows. Such initiatives are carried out expeditiously and with the same commitment to quality as those sent through pricing.

No. 106

Service Verification

Our health plan Compliance department has policies and procedures to verify with members whether services billed by providers were received. Member Verification of Services (MVS) letters, as seen in Figure V.R.106-1, are sent to a random sampling (2%) of Healthy Blue members who had claims paid the prior month. Healthy Blue IT generates the notices that are mailed each month based on the requirements document established for the Nebraska market. Healthy Blue's Publication Services Delivery team prints MVS letters in hardcopy and mails to members via U.S. Postal Mail. Healthy Blue MVS letters include:

- Description of the service furnished
- Name of the provider furnishing the service
- Date on which the service was furnished
- Amount of payment made for the service

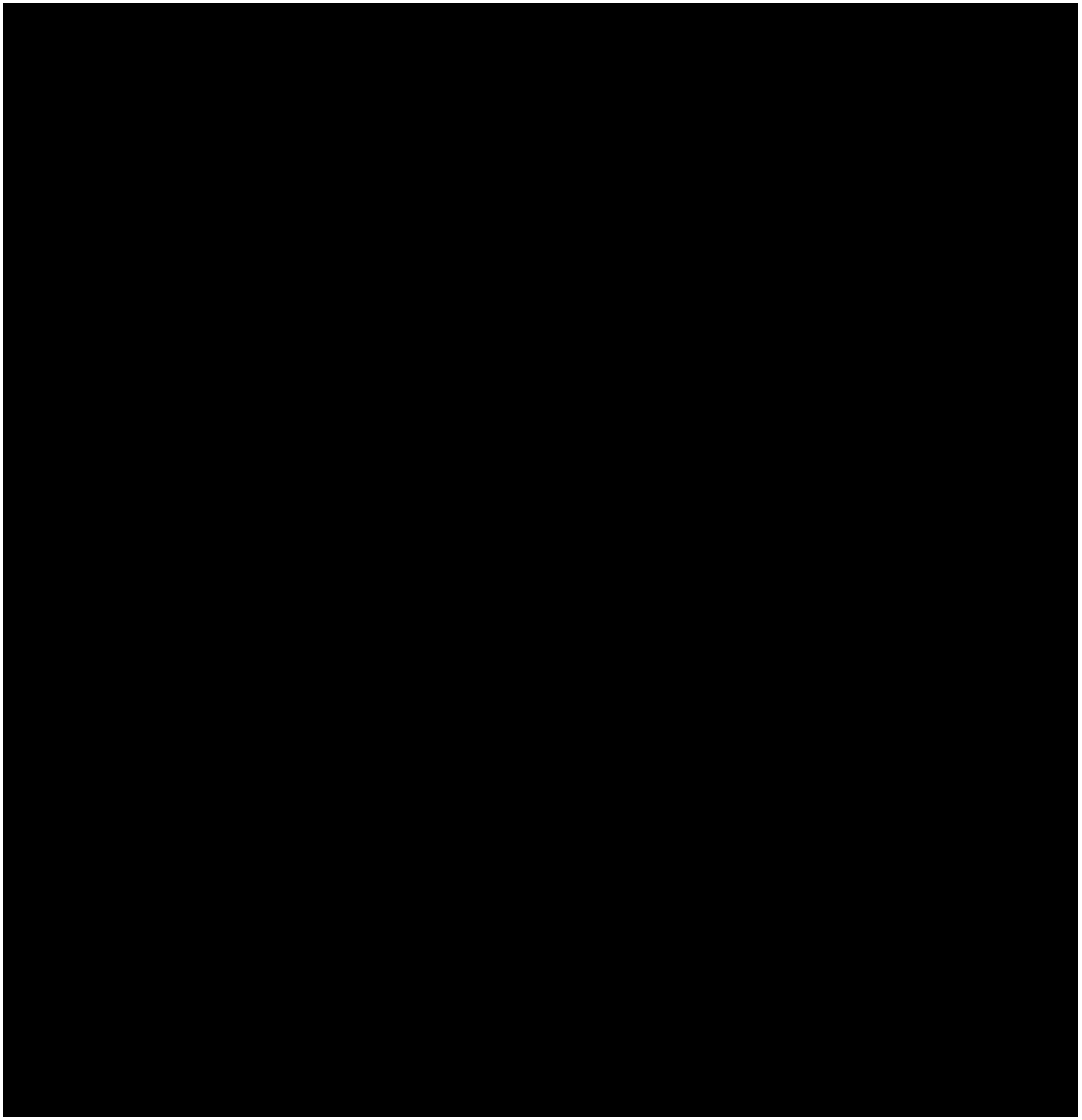
The MVS letter provides two options for members to respond:

- Call Healthy Blue's Fraud, Waste, and Abuse (FWA) Hotline (toll-free number) provided in the letter to report potential fraud
- Call the Healthy Blue MVS Mailbox (toll-free number) to leave a message with their feedback regarding the services listed

Results of sent letters will continue to be submitted to MLTC on a quarterly basis using the service verification reports that itemize each case where members responded to MVS letters.

A Healthy Blue employee monitors/records any and all messages left on the Healthy Blue MVS Mailbox. Member feedback is entered into a database to allow for:

- **Investigations by Healthy Blue SIU staff.** Any information in the member's response indicative of potential FWA activity is forwarded, along with a PDF copy of the MVS letter, to Healthy Blue SIU for review by SIU staff to identify potential FWA activity and conduct investigations as appropriate
- **Regulatory Reporting.** Each quarter, MVS letter feedback metrics and outcomes are reported to the State of Nebraska via the Service Verification Report



No. 107

Pharmacy Claims Processing and Drug Reference Database

Healthy Blue has been overseeing pharmacy benefits in Nebraska since January 1, 2017 — when the pharmacy benefit was carved into managed care. Our experience combined with the experience of IngenioRx, our Pharmacy Benefits Manager (PBM), brings to Nebraska and DHHS more than 33 years of organizational experience in managing pharmacy benefits for our partners.

We seamlessly transitioned more than 100, 000 members to IngenioRx on January 1, 2021 (with prior approval from DHHS).

Our dedicated Pharmacy Director, Shannon Nelson, PharmD will continue to work collaboratively with our PBM and MLTC to coordinate the necessary clinical services and to assure appropriate pharmacy benefit design, decision-making criteria, and formulary exceptions are followed based on Nebraska's preferred drug list (PDL) and utilization management (UM) criteria.

Our PBM adjudicates pharmacy claims online and in real time through a rules-based Point of Sale (POS) system that uses one integrated claims processing rule. Our claims regulatory report indicates we processed and paid more than one million claims last year. All participating retail network pharmacies submit claims electronically through the system 24/7/365. Our frontline safety review prevents medication issues at the point of dispensing. When a claim is adjudicated, our systems evaluate the complete patient drug history and sends real-time alerts to the dispensing pharmacist every time a safety issue is triggered.

Our PBM's claims processing system performs:

- Eligibility verification
- Claim adjudication
- Provider validation
- Duplicate claims edits
- DUR edits online in real time

Healthy Blue's PBM receives drug reference data and utilizes this data to adjudicate pharmacy claims. It uses Medi-Span, a national drug data compendium for average wholesale price (AWP) and drug classification information for POS drug reference files (SOW R.6.C).

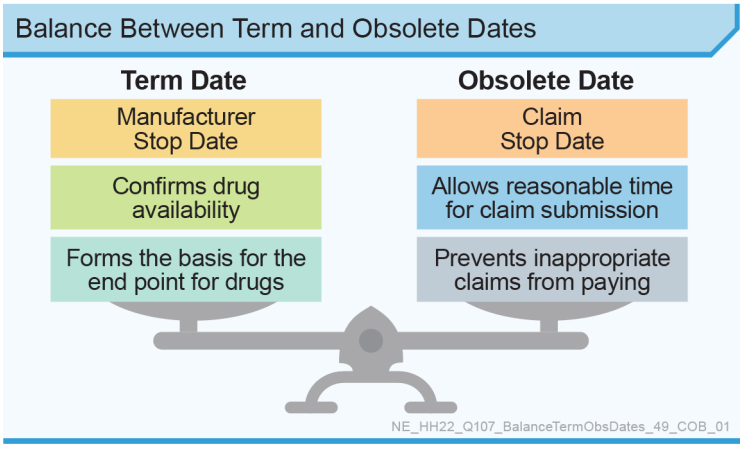
Medi-Span provides the foundation of the drug information in our claims processing system. All claims bump up against this Medi-Span foundation to assure accuracy. The Medi-Span file confirms drug information including validating NDCs, verifying drug availability, and assuring inclusion of new drugs in the market. The Medi-Span file provides the background drug information for the weekly State PDL NDC files and for Healthy Blue managed drugs.

In compliance with SOW E.9.10, our PBM can cross-reference drug databases such as Medi-Span and First Databank (FDB), if needed. When converting Medi-Span and FDB, our PBM uses product National Drug Codes (NDCs) to crosswalk between the files and then conducts an analytical review for the conversion process to verify all product label names align and to assure they have converted to the appropriate coding for the right drug and drug class. Making sure drugs are identified correctly assists with managing and correctly applying the state PDL criteria.

Update Schedule, Including Term Date, Obsolete Dates and Rebate Status

Our PBM receives daily drug file updates from Medi-Span, including amendments to drug file pricing. Pricing updates are available in the claims processing system effective around midnight on the date they are received. Updating the drug pricing file daily assures the claims are paid according to the most updated pricing information. Our PBM's claims processing system updates the NDC file weekly, including all product, packaging, prescription, and pricing information, and provides online access to reference file information (SOW S.4.e). Updating the NDC file weekly helps assure we capture new NDCs and new chemical entities, so claims are processed against the most current drug information. The claims processing system will maintain a history of the pricing schedules and other significant reference data (SOW S.4.f).

- **Term Date.** Medi-Span publishes a manufacturer-reported Inactive Date, which represents the date upon which the product in question is no longer marketed, manufactured, or otherwise available from the manufacturer. This prevents drug claims that are no longer available in the marketplace from processing.
- **Obsolete Date.** Our PBM calculates a product Obsolete Date by adding 90 days to the manufacturer-reported Inactive Date. A product is eligible for claim adjudication through its associated Obsolete Date. This assures pharmacies have a reasonable amount of time to submit claims for the products remaining in their inventory.
- **Rebate Status.** Medi-Span is our primary resource for CMS rebate status. CMS-rebateable drugs are flagged in Medi-Span at an NDC level and updated weekly. In addition, our PBM also verifies NDC accuracy against the quarterly CMS Medicaid Drug Rebate file on the CMS website site to assure NDC level and drug manufacturer level information (labeler information) is correct and complete. CMS rebate status is used to prevent claims for non-rebateable, non-covered drugs from being paid at the POS.



Our plan configuration is designed to assure that the date of service of the claim is not past the manufacturer obsolete/termination date or CMS-determined termination date of the drug and the NDC is from a rebate-eligible manufacturer and drug product on the date of service of the claim (SOW S.11.c).

No. 108

Healthy Blue has integrated the Nebraska State PDL into our pharmacy systems since January 1, 2017 — when pharmacy was initially carved into the Medicaid Managed Care contracts. We use State PDL weekly files, claim limitation document, and PDL list to integrate State PDL requirements into our POS coding and prior authorization requirements. Alignment with and integration of the MLTC PDL is particularly important to us. In 2021, 93.1% of total scripts for drugs on the Nebraska State PDL were for preferred products.

In collaboration with our affiliate PBM, IngenioRx, we will continue to use the Nebraska State PDL as defined by MLTC. This includes using State-defined prior authorization criteria, quantity limits, and age and days' supply limitations designated by the Nebraska PDL and associated claims limitation document. Our PBM will continue to integrate the PDL into the POS pharmacy claims system.

Healthy Blue oversees our PBM to assure that the approved changes to the PDL are submitted for system coding within the State's required turnaround time. All updates will be evaluated for accuracy prior to implementation to achieve accurate adjudication of each medication claim at the POS.

PDL Integration into the Point-of-Sale Pharmacy Claims System

Healthy Blue, in collaboration with our affiliate PBM, manages the pharmacy benefit according to the State PDL for State-managed drugs, adhering to all of Nebraska's requirements including PA criteria and utilization edits as required by the State.

We have an established process in place to update the PDL status of drugs per weekly and biannual PDL NDC and UM files. Once we receive the files from MLTC, we proactively work to code the UM edits and preferred or non-preferred status of drugs to be live on the specific future effective date. Our coding team cross checks all the details associated with each drug such as specific age and quantity limits, or clinical PA criteria to assure they are maintained as the status of the drug is updated. This process assures alignment to the new PDL status of the drugs on the effective date of the PDL update.

Additionally, we review and update our PA criteria to align with any drug-specific criteria or PA forms to reflect any changes.

Our website and searchable formulary tool are updated to align with PDL changes to match the effective date of the PDL update. State age and quantity limits are integrated into our online searchable formulary tool and a link to the updated PDL documents are available on the Healthy Blue Pharmacy webpage. Changes to drug-specific and class-specific PA criteria are updated and loaded into our pharmacy PA system to assure the correct question sets are applied to PA requests for Nebraska members. When possible, PDL PA criteria are incorporated into our electronic PA processes using look back logic and submitted ICD-10 codes entered at POS when appropriate.

We will continue to use established policies and procedures to make timely changes to the formulary and PDL per the MLTC guidance. MLTC sends a weekly formulary file and our PBM picks up the file directly, thereby eliminating potential time delays.

They review the file for changes and update the Nebraska POS coding through their standard processes to ensure claims are adjudicated correctly. The weekly files are coded and active within five business days. Larger biannual files related to the twice-a-year Pharmacy and Therapeutics (P&T) committee changes are loaded to be active on the effective date. We use the formulary file and are compliant with the use of those files to drive the pharmacy benefit. Our weekly and biannual changes undergo significant testing before being promoted to active status.

The POS system is easily reconfigurable when new drugs and diagnoses are added, removed, or any associated UM criteria is updated. Our PBM structures smart and electronic PA criteria within the POS system with effective dates for the system to apply benefits appropriately based on dates of service. These processes govern the implementation of any code and configuration changes made, including the execution of required testing and documentation tasks. When criteria are updated, we work with our PBM to identify changes to clinical rules and synchronize the timing of changes to make sure that both formulary and clinical rule changes happen simultaneously. Experienced adjudication coders confirm that the PDL is updated accurately and in compliance with requirements.

Recognizing the complexity of the pharmacy benefit coding process, we incorporate quality assurance checks within the formulary coding process at multiple points to assure accuracy and our ability to adjust coding promptly when necessary to adhere to the MLTC PDL and pharmacy benefit design.

Additionally, our proprietary claims surveillance program reviews approved claims to make sure they adjudicate according to the benefit design. This early surveillance allows for prompt adjustments to the coding and optimal adherence to the Nebraska pharmacy benefit design. All criteria and edits we apply to State-managed drugs are included in the searchable formulary tool, which is readily available through our provider and member websites with direct links to the State PDL.

Serving members through integrated care is our top priority at Healthy Blue.

We make sure that the real time, POS process system incorporates updates to the State PDL. This allows our PBM to accurately verify claims for formulary compliance, eligibility, drug coverage, plan design, and Pro-DUR upon receipt.

Real Time Benefit Check

Another way the MLTC PDL is integrated into our systems is through our Real Time Benefit Check (RTBC). When Healthy Blue providers adopt our online prescribing tools through their EHR, they have access to real-time, member-specific prescription drug benefit information at the point of care, which includes:

- Formulary status of selected medication
- Preferred formulary alternatives
- Coverage alerts, including PA and step therapy

State PDL changes are updated in the RTBC so that prescribers have current, up-to-date information during the e-prescribing process. This functionality helps providers determine prescription coverage more quickly by sharing information about preferred medications and coverage alerts such as PA requirements before sending a prescription to the pharmacy.

For example, if a medication requires a PA, preferred drugs may be suggested as a possible option, which the provider can discuss with a member before they leave the office. RTBC increases provider satisfaction by showing all drug options at the time of prescription, which can avoid unnecessary PA requests and allows for quicker member access to needed medications.

Electronic Prior Authorization (ePA)

There is also integration of PDL criteria in the ePA process that allows providers to initiate PA requests and track their status, helping members get quicker access to medications they need. The ability to receive automatic approvals with ePA expedites the process, reduces administrative burden, and fosters positive member and provider experiences. The ePA programming logic identifies the member, determines if the prescription requires a PA, and presents the criteria to the provider in real time.

The PA criteria question set has decision-tree logic to present only the questions required to determine medical necessity. Once a provider answers all required questions, they submit the responses for medical necessity determination. When appropriate, the provider can receive automatic approvals.

AutoPA

We will also continue to support AutoPA through the POS claims processing system which integrates PDL criteria. AutoPA uses intelligent and automated logic that reviews integrated medical and pharmacy data against drug-specific PA criteria based on the MLTC PDL.

Our pharmacy claims processing system imports the member's diagnosis from our medical claims system to approve PAs seamlessly when a medical necessity determination only requires an appropriate diagnosis to meet criteria. In addition, pharmacies may also submit ICD-10 codes to provide the diagnosis at POS. If the medication meets medical necessity, the claim continues through the adjudication process without a hard stop denial, which would require the provider to submit a PA.

This functionality eliminates the need for the provider to submit a traditional PA request, making this process efficient and less burdensome for the provider and eliminating service delays for the member.

In 2021, the use of AutoPA led to a [redacted] in PA volume for providers. This process also allows us to be compliant with continuity of care requirements that apply to specific drug categories such as anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants.

We will continue to be a partner to the State of Nebraska and MLTC. Our local Pharmacy Director, Shannon Nelson, PharmD, has regular communication with the State regarding clarifications needed on the PDL. For example, communication may be needed when we find drugs that have fallen off the files or when there are discrepancies between the State PDL NDC files and the posted PDL PDF files.

In addition, we can leverage our PBM's P&T Committee to provide recommendations to the State for changes to the PDL.

No. 109

Encounter Reporting

Healthy Blue understands and complies with the requirements to maintain policies, procedures, and mechanisms for reporting timely and accurate encounter data. Because reporting timely and accurate encounter data is essential to a successful partnership with MLTC, we have invested in significant improvements that enable us to and meet or exceed encounter submission requirements.

Healthy Blue has transitioned encounter data submission from a department-specific function into a plan-wide priority, establishing an Encounters Governance team comprised of health plan leadership and encounter subject matter experts. This team is led by Encounter Data Quality Coordinator, Mona Ahmed, and meets every other week to review current encounter submission status, assess progress, and resolve issues. This approach has proven extremely effective for quickly removing barriers to assure timely and accurate encounter submissions.

By aligning the Encounters team's actions with executive priorities of meeting contract compliance and creating communication channels that expedite issue resolution, we have seen significant improvement in our quarterly and year-end MLTC Encounter Data Quality Reports. By tapping into the expertise of our national organization and experience of affiliates from other markets, we continually gain knowledge and additional tools we can use to increase the timeliness and accuracy of our encounter submissions.

The encounters process interfaces with our claims processing system and our data warehouse (for encounters submitted by our subcontractors). Data interfaces for claims processing are shown in Figure V.R.109-1. The encounter process loads all non-pharmacy encounter claims into a single database. We apply pre-cycle edits to confirm that the data files we submit are accurate and complete. We transmit encounter files to the State's Fiscal Agent. Our integrated encounter solution will produce and submit HIPAA 5010 ANSI X12 837 transactions in professional and institutional formats, as well as National Council Prescription Drug Programs (NCPDP) formats. Encounter files will be built and submitted in accordance with State companion guides and payment rules. We carefully review responses from the State and investigate, correct, and resubmit rejected encounters.

Our encounter reporting process is shown in Figure V.R.109-1.

Uses of Encounter Data

Healthy Blue understands and complies with the requirements to submit an encounter claim to the State Fiscal Agent or its designee for every service rendered to members for whom Healthy Blue either paid or denied reimbursement.

Submitting Encounter Claims. We base our claim and encounter edits on MLTC program requirements and provide MLTC with the information to perform rate setting, quality improvement monitoring, contract compliance, and utilization analysis. If an encounter fails one or more edits, we route it for triage and correction so it can be resubmitted.

Fee-for-Service Equivalent Detail. Our encounter process includes FFS equivalent detail for claims and edits that check for the presence and validity of required, FFS equivalent detail, including but not limited to:

- Procedures
- Diagnoses
- Place of service
- Units of service
- Billed amounts
- Providers' identification numbers
- Detailed claims data required for quality improvement monitoring and utilization analysis

Policies, Procedures, and Mechanisms for Encounter Data Reporting

Our successful encounter submission process is guided by written policies and procedures that document a comprehensive schedule of system processes, review tasks, and submission dates that allow us to deliver timely encounter data to MLTC in accordance with the State's Companion Guides.

Healthy Blue will continue to comply with MLTC's standards, including its audits and validation activities. We will attend meetings; provide background information on encounter data submissions; provide access to Healthy Blue's systems, records, and personnel that can assist auditors with their work; and promptly respond to all information requests from the State and its auditors.

As detailed in our response, Healthy Blue understands and will comply with the requirements to submit institutional, pharmacy, dental, vision, transportation, and other professional encounter claims in an electronic format that adheres to the data specifications in the State Fiscal Agent's Companion Guides and any other State or federally mandated electronic claims submission standards. While dental is new, based on our history and compliance with submitting data from other subcontractors, we are prepared to do this with dental.

Our submission schedule meets MLTC submission requirements and allows additional time for error review and remediation.

[redacted]

Required Fields. Every encounter claim submission includes:

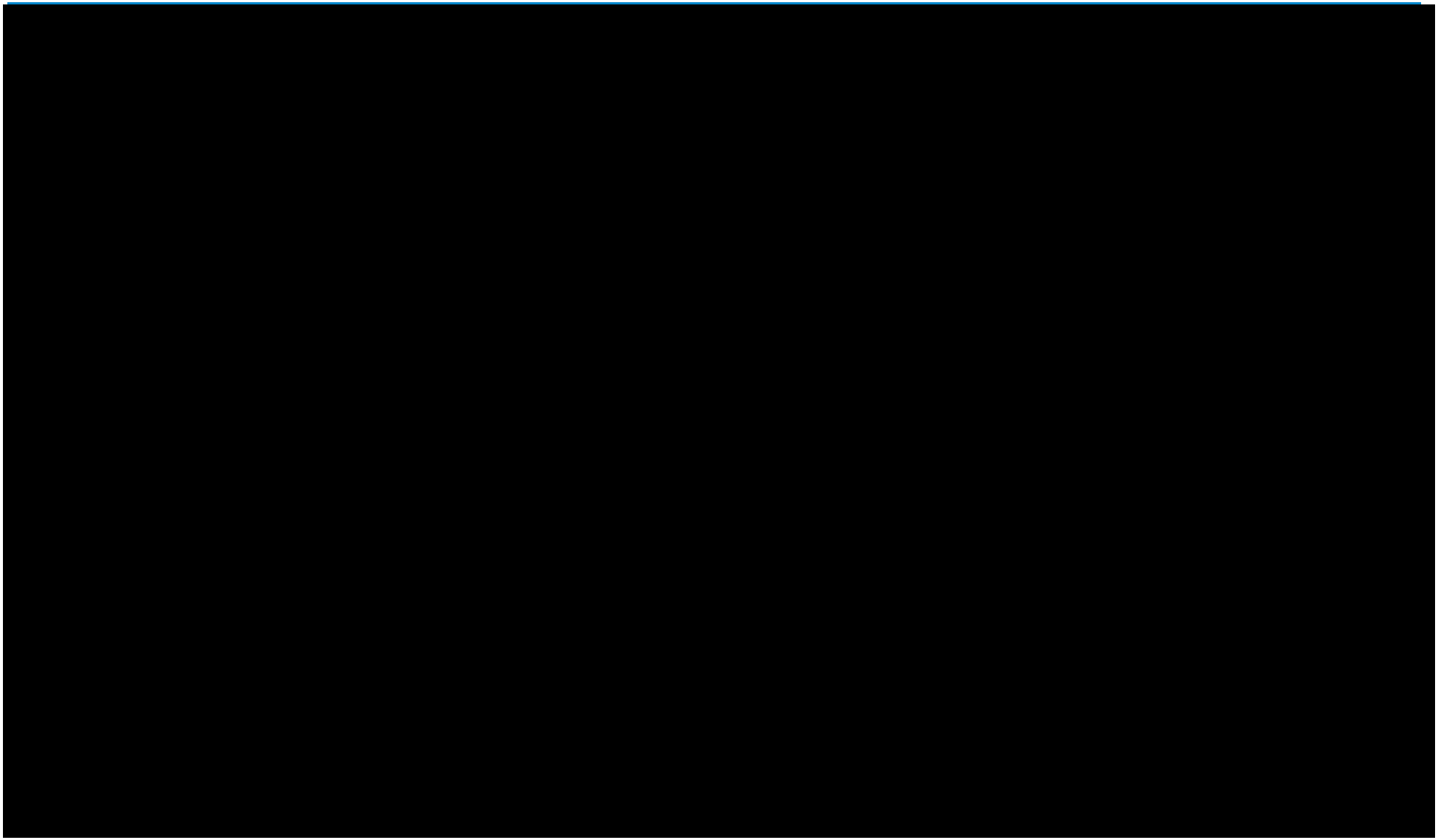
- Diagnosis code
- DRG National Drug Codes (NDCs) when an encounter involves products or services with NDCs
- Claim payment status
- Claim type

Claims Submitted via Secure File Transfer Protocol Every Wednesday

We process encounters weekly and submit via SFTP no later than 2:30 p.m. CT. These include:

- Complete batch encounter data for all adjudicated claims for paid and denied institutional, pharmacy, and professional claims
- Any claims not submitted previously

We understand MLTC uses an overall average of calendar month submissions to assess compliance with encounter claim submission requirements.



Auditing and Validating Encounter Data Submission

Data Verification. To support clean encounter data, we apply front-end edits on claims in accordance with MLTC requirements. This results in the pending of claims that need to be reviewed and worked by market analysts, health plan Claims teams, or other support teams to be resolved, corrected, and submitted.

Data Accuracy. We leverage proven systems, controls, operational processes, and experience to guard against waste, fraud, and abuse. By combining the local expertise of our health plan employees with our proven national processes and resources, our Program Integrity organization employs a variety of tools and processes to make sure services delivered to eligible members are effective, efficient, and provided — with associated payments made — by legitimate providers. As a part of Healthy Blue's Program Integrity organization, the Special Investigation Unit (SIU) closely monitors claims to make sure providers are not billing for services that are not rendered.

Collecting Complete Data. Our weekly encounter process retrieves claims records for every service rendered to a member for which Healthy Blue either paid or denied reimbursement. We run incoming claims and encounters against edits that check for the presence and validity of required, fee-for-service equivalent detail, including:

- Member data, including State-assigned ID
- Date of service
- Diagnosis codes and service diagnosis pointers
- DRG
- Procedures/Revenue codes
- NDCs
- Place of service
- Units of service
- Billed amount
- Billing provider taxonomy, NPI, and physical location address (including ZIP+4)
- Rendering provider taxonomy, and NPI
- COB payer paid amount
- Amount paid
- Date of adjudication
- Date of payment/check date
- Adjustment information

We base our claim and encounter edits on MLTC program requirements and provide MLTC with the information they need to perform rate setting, quality improvement monitoring, contract compliance, and utilization analysis. If a claim or encounter fails one or more edits, we return it to the submitter for correction and resubmission.

The encounter collection process selects newly adjudicated, voided, and adjusted claims processed since the last submission and loads the data into our encounter staging area. The number of claims is verified against the source data. If counts do not match, we identify the encounters causing the gap, resolve the issue, and rerun the process.

Subcontractor Claims Data. We have processes in place to closely monitor the encounter submission schedule for each subcontractor. If we do not receive a subcontractor file by close of business on the due date, the Subcontractor Load Management team sends an email alert, prompting outreach to the subcontractor to check the submission status and the reason for the delay. Subcontractor Load Management tracks the receipt date and status (accepted or rejected, and the reason) of each subcontractor submission and sends a daily email to business owners showing the status of all files. Late and rejected files remain on the daily broadcast until resolved. We review subcontractor encounter data against the same comprehensive edit routines as internally processed claims and hold our subcontractors accountable for correctly submitting all required and key field combinations.

Submission Timeline. We process encounters weekly and submit via SFTP no later than 2:30 p.m. CT. We have designed our submission schedule to meet MLTC submission requirements, with additional time allowed for review and remediation of any errors. We understand MLTC uses an overall average of calendar month submissions to assess compliance with encounter claim submission requirements.

Data Validation and Correction. We create HIPAA-compliant ASC X12N 837 formats to submit institutional and professional encounters as required by the State's Companion Guide. All pharmacy encounter data, which comes from our PBM, follows NCPDP format standards, and includes the exact amount paid to pharmacies.

File Approval. The Encounter Submission Analyst completes a checklist and requests approval from the Encounter Submission Manager to submit the file. Once approved, the file is submitted.

State Response and Error Remediation. Weekly, Healthy Blue's Encounters team reviews details from MLTC pre-cycle edits, researches errors, and updates the encounter's status within our encounters system, and tracks error correction and resubmission. Healthy Blue corrects and resubmits encounter errors that are identified during the pre-cycle process in accordance with the timeframe specified by MLTC. We review submission reports weekly, work through identified errors, and monitor compliance with MLTC encounter reporting requirements.

Maintaining Monthly Technical Meetings with MLTC

When the Encounters team has questions or issues they cannot resolve without input from the State or the State's Fiscal Agent, the team addresses these through email communication with MLTC. We reach out directly to MLTC if there is an urgent issue that requires immediate attention.

As required, Healthy Blue provides to the auditors:

- Background information on encounter data submissions
- Access to systems, records, and personnel

All State information requests receive a timely response.

Participating in Developing the Data Exchange Process. During the monthly technical meeting with MLTC, Healthy Blue technical support staff ask questions related to data exchange issues or encounter data transmission reporting issues. They also use this time to report encounter data submissions problems we are experiencing to our designated MLTC Policy Analyst.

Supporting a Culture of Continuous Improvement

As part of our culture of continuous improvement, we regularly review these policies, procedures, and systems to identify ways to streamline operations, increase efficiency, and improve overall performance. We are dedicated to meeting all State requirements for encounter reporting.

Maintaining Encounter Claims Work Plan for Monitoring and Improving Encounter Claims Submission

Weekly, Healthy Blue's Encounters team reviews details from MLTC pre-cycle edits, researches errors, updates the encounter's status within our encounters system, and tracks error correction and resubmission. Healthy Blue corrects and resubmits encounter errors that are identified during the pre-cycle process in accordance with the timeframe specified by MLTC.

As a part of our encounters work plan, we perform our own completeness validation using Check Book, an internal reconciliation tool that compares financial paid claims to accepted encounters. Consistently reconciling back to financial paid claims allows us to leverage the rigor employed by our Accounting, Actuarial, and Third-Party Audit teams as another check against encounter submission health and completeness. We update claims and encounter data within the tool daily. When the completeness measure for encounter data falls below our internal standard of 99%, the Encounter Governance team performs a root cause analysis and creates a remediation plan. This information is shared with MLTC if requested. Healthy Blue works closely with our Nebraska Subcontractor Management team to address subcontractor submission issues and holds subcontractors to the same completeness standard.

Our Encounters team also reviews the monthly Top 10 Rejection reports released by the Fiscal Agent and engages tactical workgroups for analysis and remediation of these issues. Past solutions have included:

- Enhancements to Healthy Blue's provider validation logic to more closely align with MLTC's pre-cycle edits
- Data mapping changes to address billing and rendering NPI issues
- Review of procedure code edits to confirm accuracy of claims adjudication and appropriate provider education

Timeliness of Contractor's Encounter Claims Submission. [redacted]

Compliance with Pre-cycle Edits. After the State or its designee assesses each encounter claim for compliance with pre-cycle edits, Healthy Blue corrects and resubmits any encounter claims that do not pass the pre-cycle edits.

Accuracy of Encounter Claims Detail. Healthy Blue demonstrates it implements policies and procedures to assure encounter claims submissions are accurate and represent the services provided and that claims are accurately adjudicated according to our internal standards as well as all state and federal requirements. Healthy Blue fully complies with the requirements of MLTC's review and audit and provides all requested documentation, including provider and encounter claims submissions and medical records, with a corrective action plan submitted for compliance remedies for any Healthy Blue shortfall in complying with encounter claims accuracy reporting standards. [redacted]

Completeness of Encounter Claims Data. Healthy Blue has a system for monitoring and reporting provider claims and encounter data completeness (that is, for every service provided, providers submit corresponding claim or encounter data with claim detail meeting requirements for FFS claims submissions, including NDCs as applicable).

Boosting Encounter Reporting Performance in Nebraska with Edifecs

Our Edifecs configuration populates enhanced online dashboards and status reports we use to monitor and assess our encounter performance. During monthly meetings, which include our CEO, Dr. Robert Rhodes, Contract Compliance Officer, Program Integrity Officer Jennifer Bohnhoff, Chief Financial Officer, Claims Administrator, Chief Operating Officer, Operations team, and the Encounter Management team, there is opportunity to review encounter performance and discuss any issues or concerns. This shared responsibility and oversight of encounter data allow us to combine local expertise with best practices gleaned from Healthy Blue affiliate health plans.

No. 110

Our parent company has an extensive track record managing individuals who are dually eligible across our affiliates nationwide. Part of that coordination of benefits activity includes supporting 8,472 Healthy Blue dual-eligible member members. We make sure services covered and provided under the contract are delivered to members who are dually eligible for Medicare and Medicaid without charge and in accordance with State and federal coordination of benefits requirements. We comply with industry standards for coordination of benefits (Medicaid is payer of last resort) and coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers, as appropriate, to coordinate the care and benefits of dual-eligible members.

We process claims that cross over from Medicare FFS. When a member is Medicare primary, we pay the Medicaid benefit without a 2nd claim. We also follow this standard claim process and automatically coordinate pharmacy claims through our PBM. When a member has Medicare benefits external to Healthy Blue, we coordinate utilization of services with the Medicare payer to ensure services are not paid under the Medicaid benefit when Medicare is primary.

Member access to needed medical, behavioral, and social services is a Healthy Blue guiding principle. Consequently, our coordination of benefits (COB) approach minimizes the impact on members. Our processes are virtually invisible to members and their families as we prospectively work directly with providers, other carriers, and metadata clearing houses to resolve COB and third-party liability (TPL) cases. In 99% of these cases, Healthy Blue accomplishes our objectives with no member involvement. We augment our COB efforts by working with our contracted and out-of-network providers to identify and resolve the root causes of inappropriate billing.

Experience with Medicare and Medicaid Coordination of Benefits

Our parent company has significant experience supporting the various components of wrap-around services, including:

- Medicaid-only services (services that do not have a corresponding Medicare service)
- Medicare services that become a Medicaid expense because the benefit limit on the Medicare side is reached (This includes the member exhausting any life-time maximums or annual maximums in either Medicare Advantage (Part C), FFS Medicare benefits (Part A and Part B), and Medicare Drug Benefits (Part D))
- Medicare services that become a Medicaid expense due to co-insurance, deductibles or copayments (true crossover claims)

We approve all needed services, regardless of payor, to make sure services are available to the member. Our protocols are designed to track members' other insurance for covered benefits as primary and that covered benefits are secondary if there is benefit overlap. Systems and procedures are in place through the claims adjudication process to recoup Medicaid monies if Medicare is the primary payor for the service(s) rendered. For instance, if we discover that we have paid a claim for a member who has other insurance, we will go back to the carrier to obtain reimbursement, not to the provider, so the provider is spared the burden filing for reimbursement with the other carrier.

Identifying Medicare and Another Health Insurance Payer

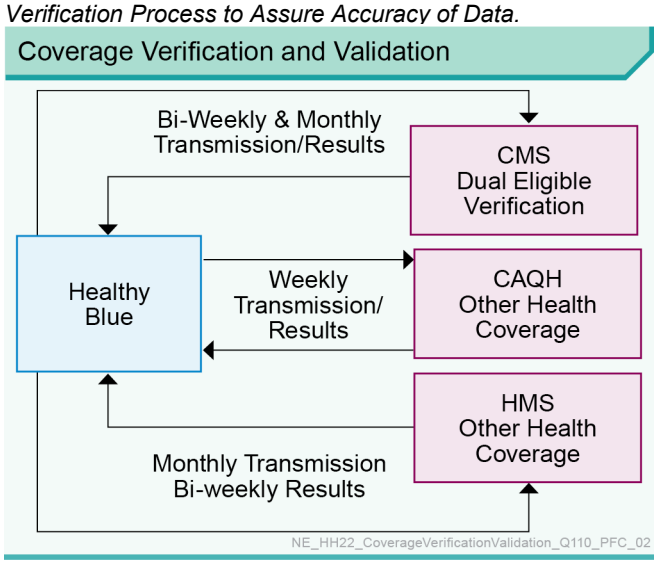
Healthy Blue is committed to maximizing its ability to identify other coverages a member may have, including Medicare, other health insurance coverage, and liable 3rd parties; avoiding claims payment when there is evidence of alternate payment responsibility; and recovering any and all overpayments. We are experienced using a multipronged approach. All our solutions are HIPAA-compliant with strong administrative, technical, and physical safeguards to maintain privacy. Our cost containment efforts foster member satisfaction as we work directly with carriers and providers to coordinate benefits, minimizing required involvement from members and their caregivers or families. Healthy Blue identifies Medicare and other health coverage for members through:

- Claims-mining processes performed on all inbound claims
- Providers indicating this information on or with claim submissions
- Vendor partnerships for acquisition of Medicare and other health insurance information
- Medicare/dual-eligible status information available via program code and/or rate group identifier on the Nebraska 834 eligibility file (Our eligibility process flexibility also includes the ability to identify D-SNP members as identified and transmitted on an 834 file)
- Daily automated CMS Coordination of Benefits Agreement (COBA) files that identify Medicare primary payments for our Nebraska Medicaid membership
- Daily Medicare, other health carrier information, and/or TPL leads received throughout Healthy Blue from members, providers, and internal member service and care management/coordination staff

Our metadata clearing house vendor partnerships (Figure V.S.110-1) provide access to extensive data repositories to identify eligibility and other payer information that may be new or modified, as well as other health carrier information that has been terminated for members. These information sharing partnerships feature:

- Two direct eligibility exchanges with CMS (bi-weekly and monthly) that return Medicare coverage details which are loaded directly to Healthy Blue member profiles
- Weekly demographic information on our members to the Council for Affordable Quality Healthcare (CAQH) to obtain weekly results that identify other participating major health plans, commercial COB
- Monthly member demographics to Health Management Systems (HMS) and receive results back bi-weekly after our information is compared to its data repository from more than 150 health insurance organizations

Figure V.S.110-1. Healthy Blue's Employs an Extensive Verification Process to Assure Accuracy of Data.



Once a member is in our system, their demographics are included in the next scheduled data extract that is provided to each vendor for eligibility and other health coverage identification. We thoroughly validate all Medicare/other health coverage leads we identify and receive internally as well as results we receive from our vendors. We will use all these sources for identifying Medicare and other health coverage information.

We will submit all potential leads for Medicare and other health coverage to a dedicated team within our COB department. Employees on this team conduct daily review of leads received from Nebraska eligibility file feeds, members, providers, and other sources, including our claims-mining processes.

Employees will verify the accuracy of the other coverage information and also make sure that the coverage data is accurately and completely documented in a member's record within our claims processing system.

Our team will also thoroughly validate any Medicare/other insurance leads we receive through our partnerships with CMS, CAQH, and HMS. Results from these vendors initially go through an automated validation process designed to help identify potential errors in the data as well as potential conflicts of information that may require additional manual verification. We use our business standards for another insurance record to validate results prior to loading. For any data not meeting the business standards, our COB team will investigate prior to loading. Once validated to be accurate and complete, we manually add the record into the system.

Integrating COB with Claims Adjudication

Our claims processing system is fully integrated with our COB and TPL processes to:

- Capture Medicare or other payer information contained on the claim to help assure payment accuracy
- Evaluate Medicare flags or other payer flags stored on Healthy Blue member eligibility records to determine Medicare/Medicaid COB
- Suspend claims where Medicare, other payer, or TPL is indicated to make sure coordination of Medicare/Medicaid benefits is accurate and consistent

Our Healthy Blue claims process effectively supports COB management by automatically incorporating a series of edits that prospectively identify and correct potential overpayments based on current Medicare/other payer information housed in a member's record.

During adjudication, our claims processing system will compare the submitted Dates of Service (DOS) to the effective and termination dates of the other insurance coverage (Medicare coverage) in the member record. If the claim DOS are within the effective and termination dates, we will suspend the claim for additional analyst review. When analysts identify a claim as eligible for COB, they will coordinate the claims based on Nebraska COB guidelines. For example, if we identify a Medicare source, but the required Explanation of Benefits (EOB) is not attached to the claim, we will notify the provider that the claim must be submitted to the appropriate third party to determine the Medicare paid amount. If the required information is attached to the claim, we will suspend the claim for additional analyst review before final adjudication. We use this information to assure that the total benefits issued by the primary carrier and Healthy Blue do not exceed the allowed amount and are coordinated correctly.

While Healthy Blue practices support prospective identification of Nebraska members with Medicare coverage, we will also coordinate benefits with the provider or alternate carrier before claims payment, when appropriate. We also conduct post-payment reviews and work directly with providers and carriers to recover payments made that are the responsibility of another payer.

No. 111

Working in collaboration with MLTC, Healthy Blue applies best practices in Medicaid data management to measure, evaluate, and refine our programs to identify areas for quality improvement (QI) and enhanced quality management (QM) activities. Our dashboards provide insight into performance related to access to and quality of care, program cost, and effectiveness. Our data-driven QM program and strategies use a proven quality measurement approach verified by national audit firms and based on the extensive experience serving the State of Nebraska and experience in our Medicaid affiliate markets. ***As an incumbent, we presently provide a comprehensive set of analytics and informatics data, including member enrollment, call center metrics, provider authorizations, grievance and appeals data, and care management outcomes data, and financial status monthly to the MLTC.*** Healthy Blue's monthly data informs the data compilation for quarterly analysis with the inclusion of Quality Assessment and Performance Improvement (QAPI) metrics data and customized visualizations and reporting to help us deliver visualization and reporting of our performance to Heritage Health initiatives and programs. Additional dashboards available as outlined further in this section will augment existing data reporting and templates required by MLTC.

Data Analytics and Informatics Drive Performance Improvement and QM Activities

Built on a HITRUST-certified and HIPAA-compliant Management Information System (MIS) and data infrastructure, our interactive quality analytics platform analyzes data at state, population, and member levels by integrating public and internal data sets with individual member information. This multi-dimensional data infrastructure is fully integrated with our operational data and includes a robust suite of automated and dynamic reporting. With dedicated, local data analytic support, we continuously assess quality data, population health trends, utilization patterns, and year-over-year performance measures to develop innovative strategies that support network providers in delivering quality care and improve health outcomes for Nebraska MLTC members.

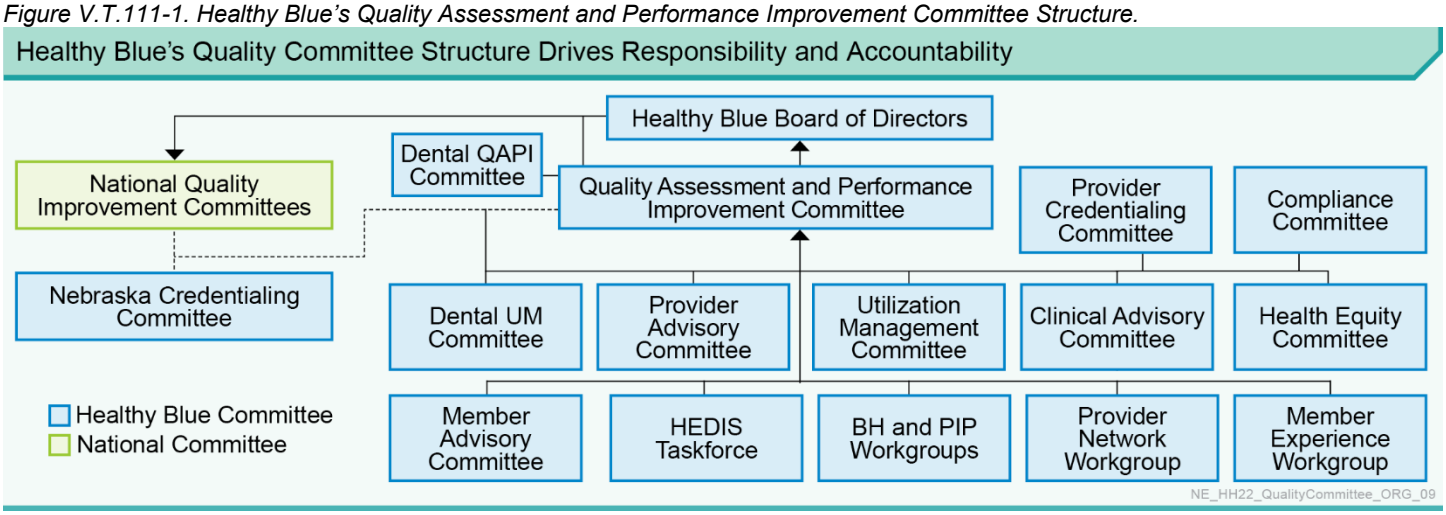
Guided by strategic direction from the MLTC's Quality Strategy, NCQA, Quadruple Aim, and our QM Work Plan, we will enact internal quality control and ongoing monitoring using comprehensive data analytics and data informatics capabilities that drive and track performance improvement and QM activities, including:

- Monitoring overall quality metric performance against benchmarks and targets
- Driving evidence-based decision-making through review of utilization trends, such as access to care, demand for services, and quality of care to inform our QM and population health strategies
- Using performance metric trends to identify opportunities for QI
- Conducting in-depth barrier and root cause analysis to identify unhealthy behaviors and their determinants
- Building out reporting capabilities to meet all Nebraska MLTC reporting requirements

Our QM/QI team tracks and trends our measures through bi-weekly and monthly reports, which we share with our internal departments, task forces, and quality committees. To identify areas for improvement in health disparities, we routinely stratify more than 20 HEDIS® clinical performance measures by race and ethnicity. We use these findings to implement interventions that target disadvantaged populations and enhance health equity.

Our QAPI Committee (as shown in Figure V.T.111-1) and Healthy Blue leadership has on-demand access to a wealth of data to assess utilization and pinpoint improvements. Our data infrastructure drives consistent, timely, evidence-based decision-making. Collecting and aggregating multiple data sources into a comprehensive source of health information about members, our local QM data analyst and Care Management team will have 24/7/365 access to critical insights, enabling innovative solutions and promoting high quality of care for our members.

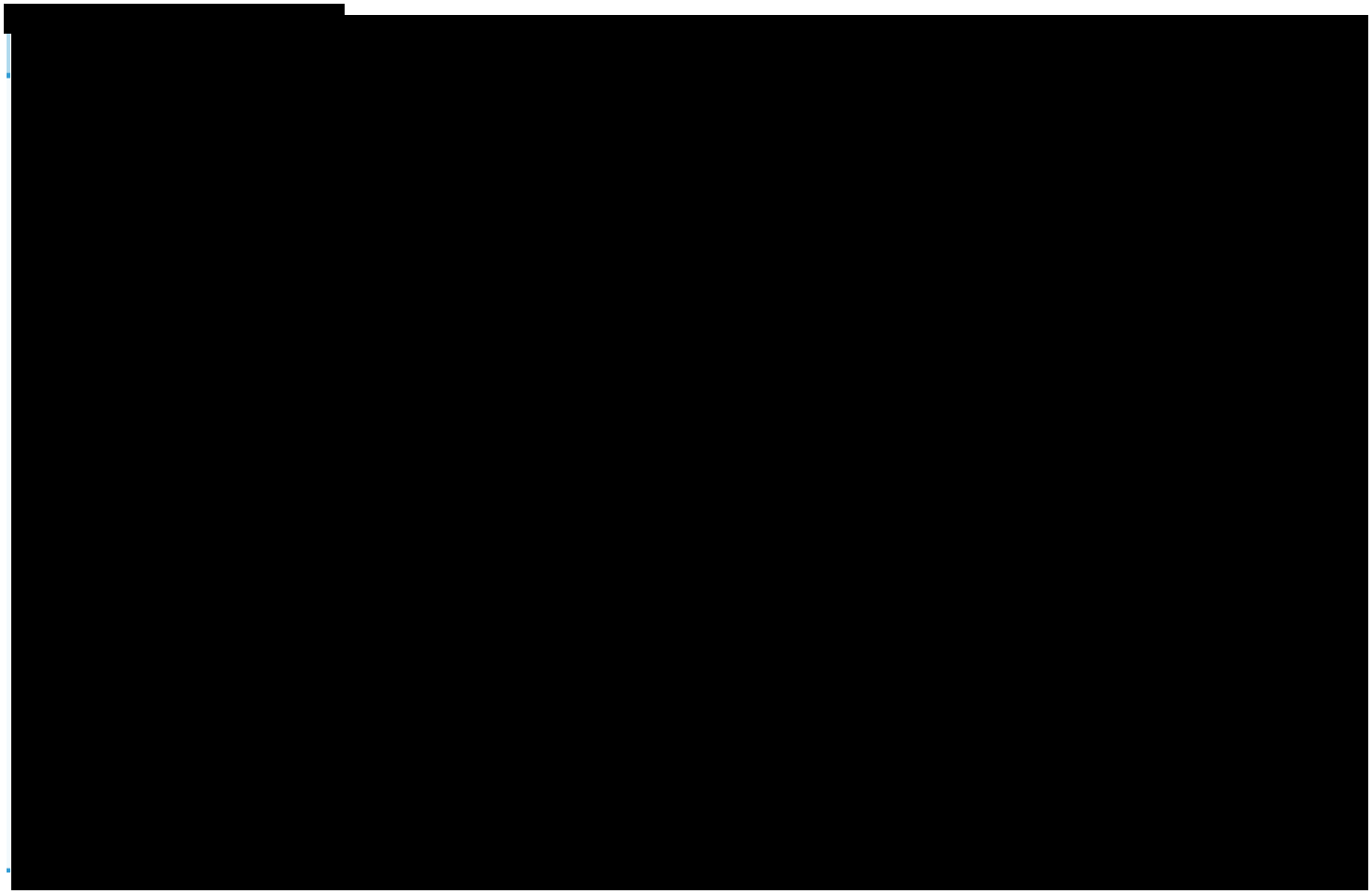
Figure V.T.111-1. Healthy Blue's Quality Assessment and Performance Improvement Committee Structure.



Comprehensive Quality Management Reporting Suite. Through our quality analytics platform, we integrate and transform data from multiple sources into actionable information that provides in-depth insight on overall performance against quality goals identified in our QM Work Plan. The following comprehensive QM Reporting Suite gives our QM team and leadership the information they need to monitor performance and identify opportunities for QI initiatives.

HEDIS Performance Rates. The QM team and the HEDIS Task Force use this report to analyze monthly HEDIS rates and identify trends year-over-year. Additionally, we analyze data against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. These performance rates will also be used to develop and monitor tailored interventions to support providers and engage Members. We provide a sample of the HEDIS Performance Rate report in Figure V.T.111-2.

CAHPS® Trending. The QM team will use the CAHPS Survey to analyze annual member experience with clinical care and services and compare performance against national benchmarks and State performance goals to identify improvement opportunities and take action. We provide a sample of the CAHPs Trending report in Figure V.T.111-3.

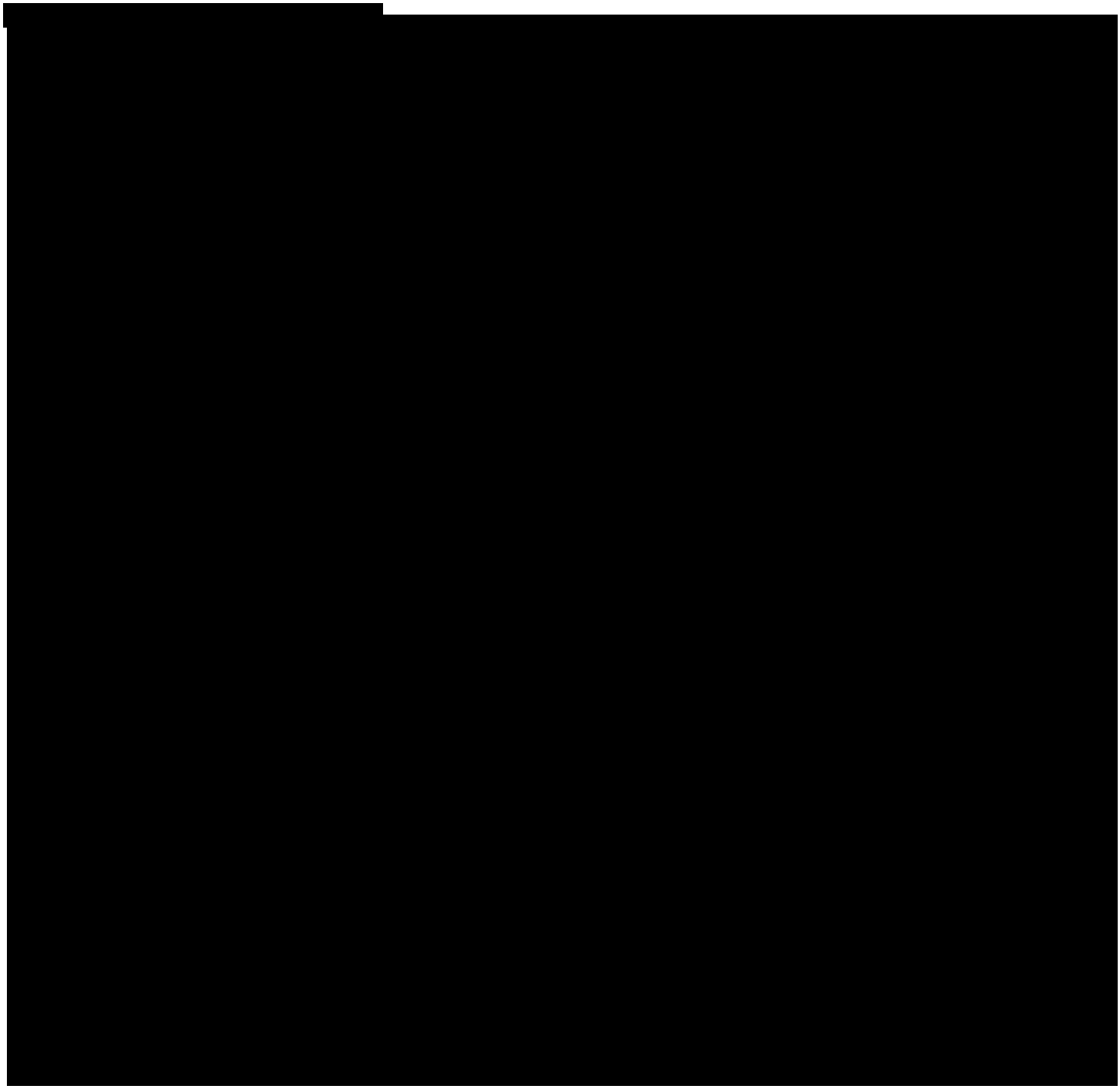


Annual Performance Improvement Project (PIP) Summary. We apply rapid-cycle improvement methodology to design and evaluate QM program interventions, including clinical and non-clinical PIPs required by the State on a bi-monthly basis through the work of our PIP Task force. A summary of our annual PIPs selected is based on identified areas of opportunity or improvement to better services or outcomes and prevent or decrease the likelihood of problems. This includes details of testing new approaches to fix underlying causes of persistent, systemic problems, or barriers to improvement. We provide a sample of the Annual PIP Summary report in Figure V.T.111-4.

Grievance and Appeals Data. We use this data to identify and monitor complaints, grievances, appeals, and reported quality of care and service issues monthly. This data also supports analysis of issues related to quality of care and patient safety and will be used to initiate peer review processes. We provide a sample of the Grievance and Appeals Data report in Figure V.T.111-5.

Annual Cultural Linguistics and Appropriate Services (CLAS) Evaluation Report. This report is an annual written evaluation of the CLAS program, which includes an assessment that helps assure the implementation of culturally and linguistically appropriate health care-related services to members with diverse health beliefs and practices, limited English proficiency (LEP), and variable literacy levels. The annual evaluation also includes a description of completed and ongoing activities for CLAS and health disparity identification, trending of measures to assess performance, analysis of results and initiatives — including barrier analysis, evaluation of overall effectiveness of the program, and of the interventions to address CLAS and health disparities. We provide a sample of the Annual CLAS Evaluation report in Figure V.T.111-6.

Interactive Quality Analytics and SDOH Hot Spotting Heat Map. This interactive tool provides visibility into quality measures and performance data trended over time based on performance benchmarks. We will use this tool to identify member- and provider-level trends, risk indictors by census, and social determinants of health (SDOH), measuring rate variance and disparities between age, gender, race, ethnicity, language, and urban versus rural to evaluate and formulate programmatic interventions. Users can drill down in data to select specific geographic areas as well as a variety of HEDIS measures to examine variables of interest to the Nebraska MLTC. Based on identified gaps in care, we will be able to create heat maps to systematically monitor for and display concentrated gaps within identified ZIP code to improve the delivery of care and services in Nebraska. We regularly analyze all HEDIS data and compare our results to internal goals, DHHS goals, and national benchmarks. We provide sample screens from our Interactive Quality Analytics Report in Figure V.T.111-7 and SDOH Hot Spot Heat Map in Figure V.T.111-8.



[redacted]

Population Health Analytics and Interactive Indexing Informatics

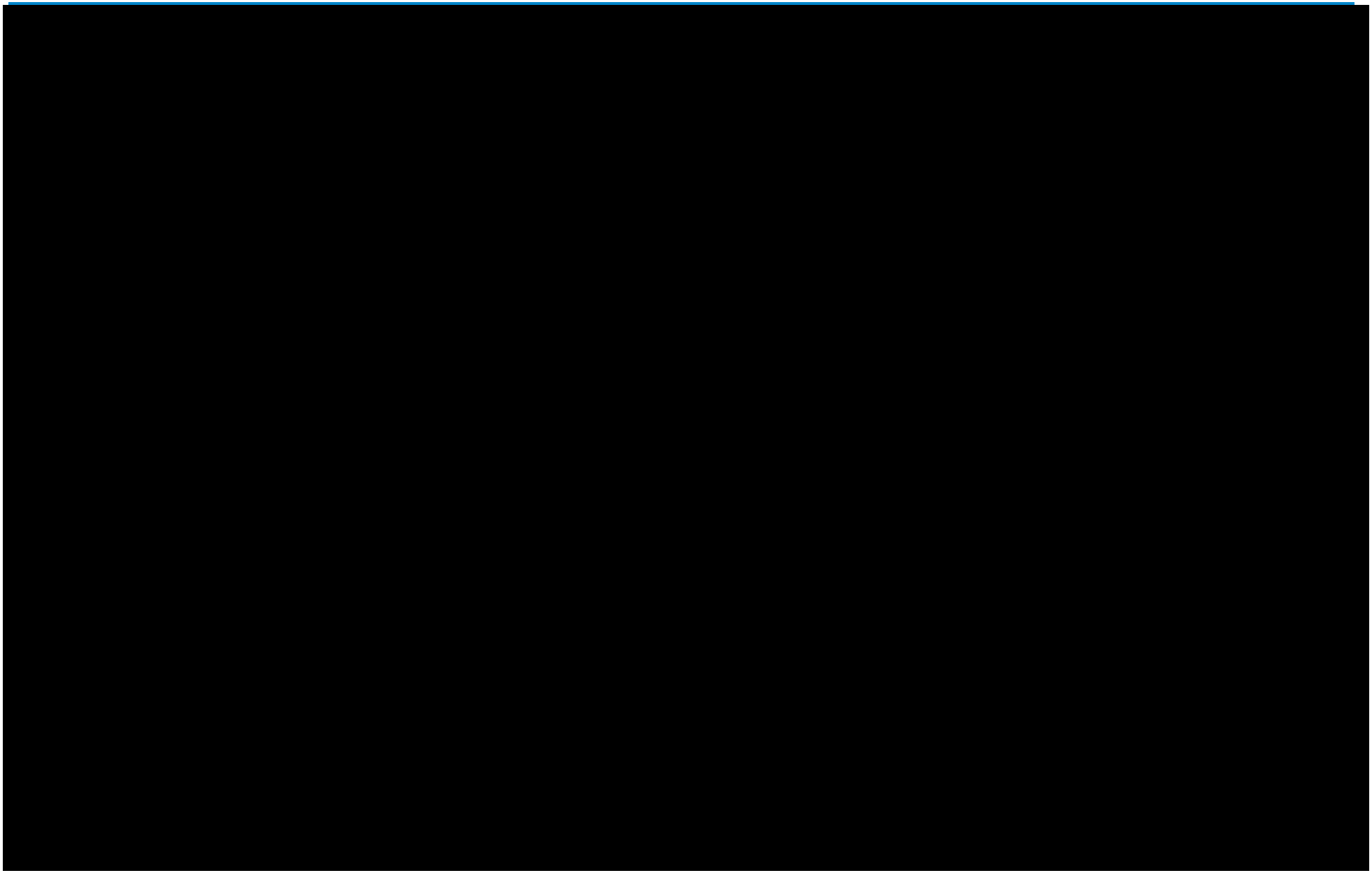
This innovative tool incorporates quality data to supplement utilization data, conditions prevalence data, condition comparative trend data, and other demographic, geographic, and historical utilization data from external entities and internal experience. We use the Population Health Analytics tool to allow us to aggregate population health statistics based on data obtained through electronic health records (EHRs) and health information exchanges (HIEs), as well as available data from the DHHS, supplemental data from key, high-volume providers, admission, discharge, and transfer (ADT) data, and public health data.

We provide a Population Health Analytics report sample in Figure V.T.111-9 and a Health Indexing Informatics sample in Figure V.T.111-10.

[redacted]

Predictive Modeling for Optimal Outreach Trends and Demographic Predictive Modeling Trends

Using tools that predict risk of readmission, emerging risk, and potential for emergency department (ED) utilization, our algorithms identify members with Low, Medium, or High risk. Additional predictive modeling tools will help us generate risk scores for subpopulations, such as our various OB or behavioral health (BH) tools, to further refine member risk level, prioritize outreach and assessment activities, and determine the scope and level of needed interventions. These predictive modeling tools will use comprehensive data integrated from a variety of sources to calculate a primary risk score. We provide a sample of the Predictive Modeling for Optimal Outreach Trends in Figure V.T.111-11 and Demographic Predictive Modeling Trends report in Figure V.T.111-12.

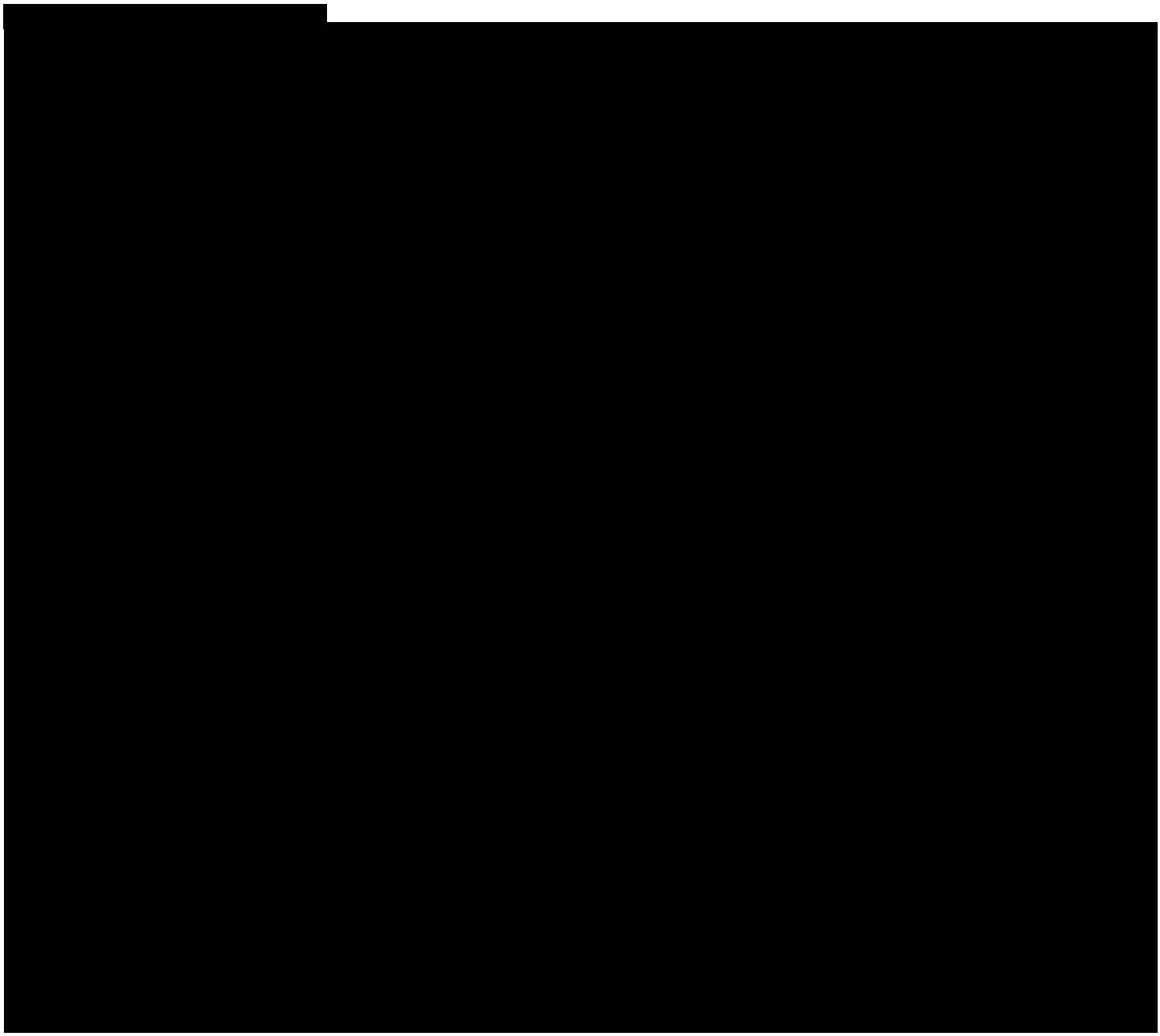


Stratification Tools. This predictive modeling tool uses transformational data analytics based on member utilization data, assessments, ADT, and other medical record data to proactively identify the level of support each member needs. As part of our population health approach, we leverage this tool to assure we meet members where they are and provide support for the best possible health outcomes.

Member-specific information is refreshed monthly through our Continuous Case Finding process using updated data sources, including updated claims, ED data, and utilization management service authorizations. Other predictive modeling tools will help us generate risk scores for subpopulations to further stratify member risk level, prioritize outreach and assessment, and determine the scope and level of intervention needed.

A recent enhancement to this tool includes two additional models that enable us to predict the likelihood of a member attempting suicide in the next 12 months and the likelihood of a member with repeat suicide attempts in the next 12 months. With this risk information, we will proactively engage at-risk members with specialized care management services and connect them with the services and supports they need.

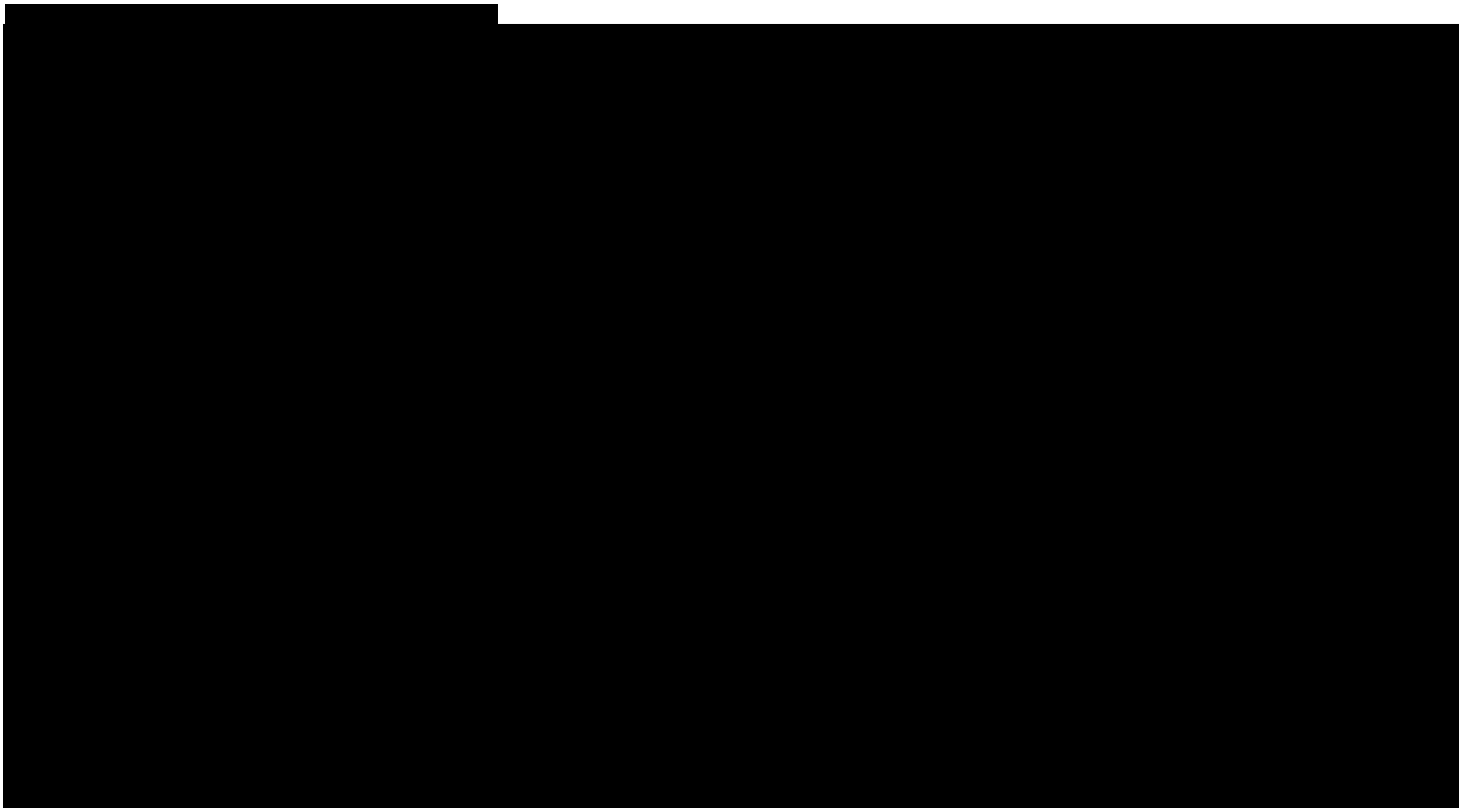
We provide sample segmentation analysis results in Figure V.T.111-13.



Care Management Trends. We collect and use a range of member-, provider-, and community-level data to inform our QM and population health strategies and establish priorities for interventions. Our analytics engine aggregates data from multiple sources, so we have in-depth insight into all aspects of population health to take steps proactively. We leverage qualitative and quantitative data using internal sources including claims, utilization, demographic, and data from external sources including:

- Published, peer-reviewed research
- Nebraska-specific public health data
- Any available data from Nebraska MLTC
- Integrated EHR data from providers (as available)
- Data from national and local organizations, such as our community-based referral platforms and local nonprofits that promote public health through projects in policy evaluation, community health, data analysis, and health access

We provide a sample of the Care Management Trends report in Figure V.T.111-14.



Member Segmentation Trends and Equity Assessments. The goal of member segmentation is to identify and classify members who will most likely access care on their own versus those who may need additional support to access. To predict member behavior and assess equity by NCQA domains and HEDIS measures, we will use statistical algorithms that combine closely determined variables of interest spanning socio-demographic variables and clinical information, among other factors.

A combined probability score is calculated for all the significant variables. These will be segmented into low probability scores, which indicate members who most likely will not access (probability score < 0.5), and high probability scores (>0.9) indicating those who will access on their own and do not need additional intervention, and a medium band between 0.5 and 0.9.

Through this data-based approach, Healthy Blue uses resources to get members into appropriate care, thereby improving HEDIS rates. We also use this data to provide member outreach through the various modalities that match their preference and likelihood of compliance.

We provide sample Member Segmentation Trends and Equity Assessments in Figures V.T.111-15 and V.T.111-16.

[redacted]

[redacted]

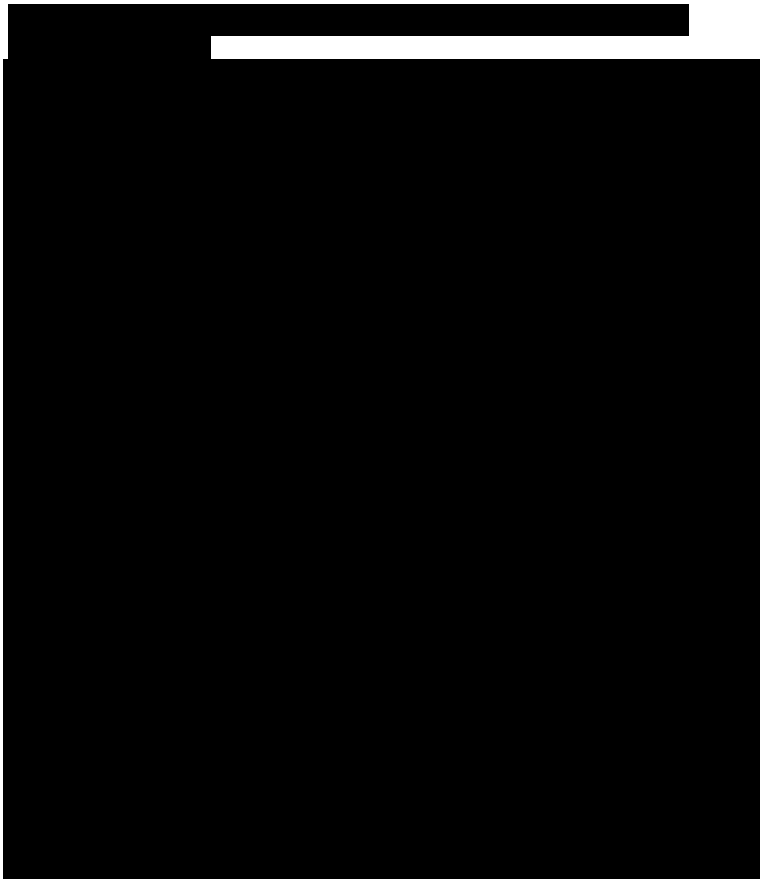
Using Provider Benchmarking and Performance Metrics to Identify Opportunities for Quality Improvement

In addition to the comprehensive suite of reporting available to the QAPI Committee and leadership, Healthy Blue also leverages value-based purchasing (VBP) provider performance reports, which provide trend data that drive our quality strategy with the providers and guides our interventions and provider education. Trend assessments may include provider performance regarding medication adherence, well-child and immunization rates, and gap closure for chronic conditions.

We will also give providers actionable, timely, and accessible data to assess their performance in our VBP programs, including population-specific health improvement opportunities and identified disparities via the following data-sharing tools:

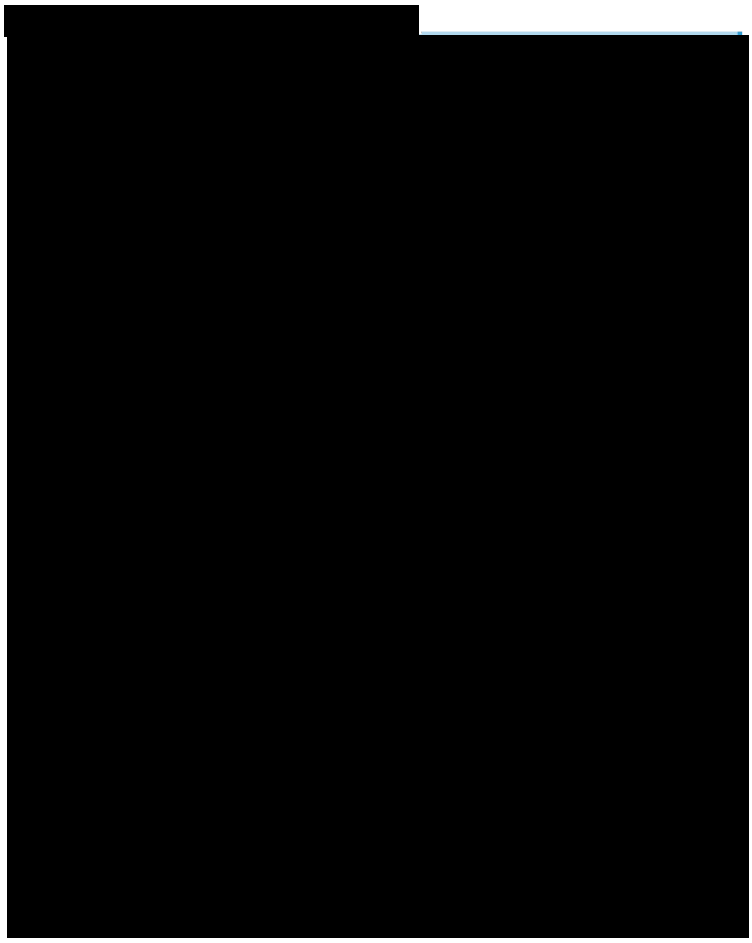
VBP Provider Scorecard and Reconciliation. Scorecards show provider performance relative to quality and cost measures and targets. Providers who participate in our Category 3 programs also will receive reconciliation reports indicating the status and results of their incentive program. We provide a sample of the Value-based Purchasing Provider Scorecard and Reconciliation report in Figure V.T.111-17.

Financial Recovery Economics Platform. This platform will enable providers to trend present performance to historical, month-to-month, and year-over-year data included. Information comes from multiple sources in a drillable format (such as Top 10 Utilizing Members) with customizable dashboard graphs, enabling users to quickly spot trends, understand the drivers, and act on opportunities to improve financial performance. We provide a sample of the Financial Recovery Economics Platform report in Figure V.T.111-18.



[redacted]

Care Opportunities. The Care Opportunities report provides PCPs a list of members with care gaps, such as missed preventive health services, and targets the need for HEDIS-measured procedures and visits such as well-care visits. It also includes member contact information so providers can easily conduct outreach. We provide a sample of the Care Opportunities report in Figure V.T.111-19.



Profile Reporting. Providers are able to compare key clinical metrics (such as preterm birth rate, C-section rate, and timeliness of prenatal and postpartum care) to benchmarks and performance of all providers in Nebraska and nationally within their specialty and panel peer groups. Due to the significant disparities in maternal outcomes, we also will include race and ethnicity data in these reports so that providers can identify and address health disparities within their own practice. We provide examples of Profile Reporting available in Figures V.T.111-20 and V.T.111-21.

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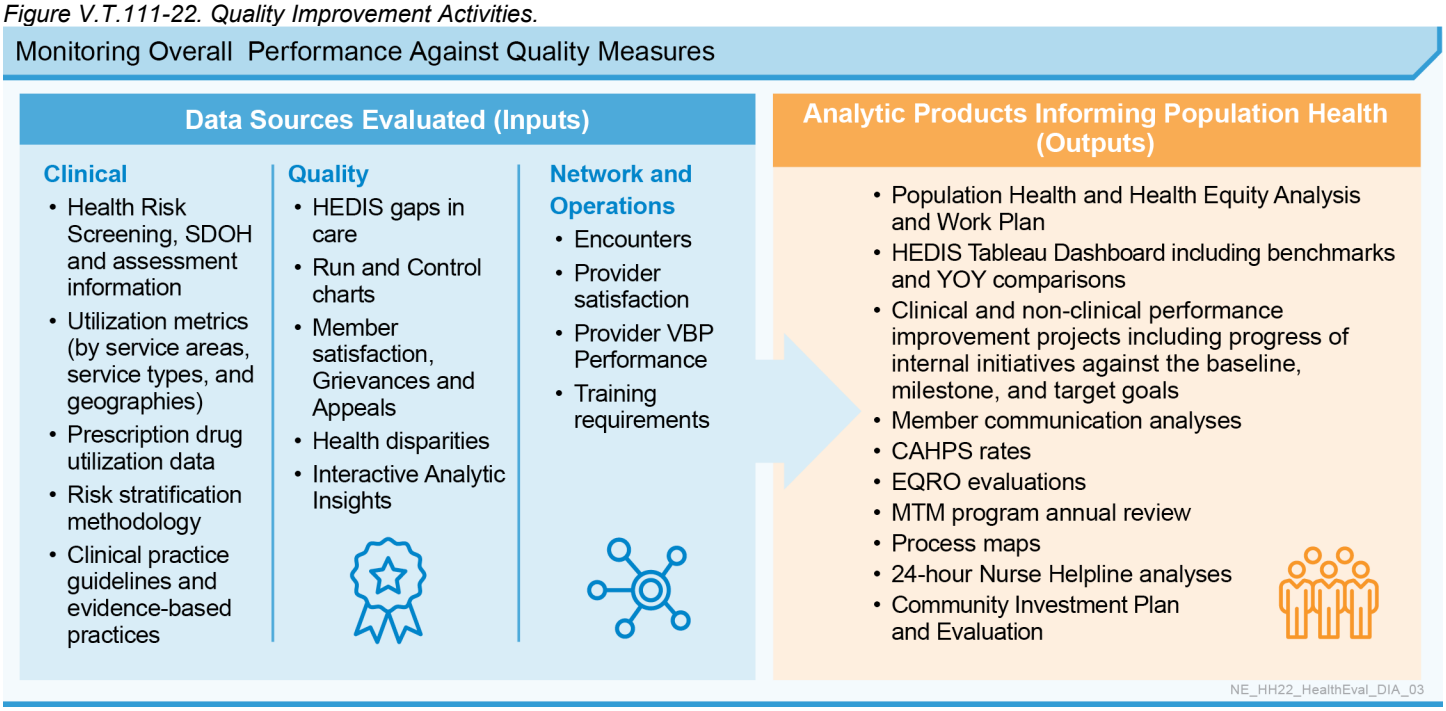
Monitoring Overall Performance Against Quality Measures

Quality Improvement Activities

Quantitative and qualitative data collection and data-driven decision-making are central to our QM/QI program. We will apply valid and reliable methods, such as our advanced data analytic tools, to continuously measure and re-measure the effectiveness of clinical and non-clinical initiatives, quality of care, access, safety, and more, including the following benchmarking activities.

We will continually monitor clinical and non-clinical data including HEDIS results. We will use NCQA's Quality Compass tool to determine national benchmarks and State-specific performance targets to compare our performance with the overall goal of exceeding national averages for the NCQA Medicaid HMO Quality Compass Percentiles. The process for monitoring overall performance is outlined in Figure V.T.111-22.

Figure V.T.111-22. Quality Improvement Activities.



Business Review

Currently, Healthy Blue participates in a monthly leadership meeting with MLTC during which we are able to share our dashboard on various lines of business and key metrics. We would like to propose enhancing that collaboration by providing additional performance data and QAPI data to the MLTC through a quarterly business review in which Healthy Blue's leadership team will review the findings, identify areas of opportunity, and develop solutions in collaboration with the State. During these quarterly business reviews, we will present our results and address any questions Heritage Health leadership may have about the timeliness of the data and the data collection methodologies, as well as provide insights into how we are using the data to inform Healthy Blue operations and strategies. At its sole discretion, Nebraska MLTC may determine that reports generated by the dashboard are sufficient and no longer require the MCO to complete similar reports. Nebraska MLTC will notify the MCO of additional reports in less than 60 days prior to the due date of those reports. Dashboards will be updated within the timelines specified by MLTC.

No. 112

Healthy Blue will work closely with MLTC during the implementation period to facilitate a seamless transition between MCOs, providers, and programs to prevent interruption of services and to ensure continuity of care for members. Healthy Blue will not reduce or deny members continued access to their providers, services, or care until we can assess medical necessity during periods of transition. We will honor existing prior authorizations (PAs) as established by the previous MCO or Medicaid fee-for-service (FFS), and will allow members to continue accessing their current providers, care, and services for up to 60 calendar days for medical, behavioral health (BH), and dental services. When we are made aware of an existing pharmacy PA, we honor the PA. In addition, we have a 90 day transition period in which new members can obtain a one month supply of a non-preferred drug without a PA. If members have ongoing treatment or special conditions, we will authorize services with those providers regardless of network status, and in accordance with Nebraska's rules and regulations (SOW E.33.a.d–X.1.a).

We show critical components to facilitating member continuity of care in Table V.X.112-1.

Table V.X.112-1. Components That Facilitate Member Continuity of Care.

Components	Descriptions
Authorizations	Healthy Blue will honor all existing authorizations, including services and identified frequency of service on the member's care plan, for up to 60 days following enrollment and as established by their previous MCO, or Medicaid FFS or until other arrangements for the transition of services can be made.
Transportation	We will arrange for initial and ongoing transportation through our Non-Emergency Medical Transportation vendor to the nearest appropriate provider.
Non-Contracted Providers	We will identify members receiving services from out-of-network providers and contact our Provider Services department for outreach and contracting. If we are unable to contract with the provider for any reason, we will work closely with the member to choose another provider or establish a single-case agreement (SCA).
Care Plans	We review new members' care plans for appropriateness of care, arrange for all medically necessary services, and identify any gaps in care, then refer the member for additional services, if needed, to help ensure a successful provider transition.
Clinical and BH Rounds	We will conduct integrated rounds weekly to discuss complex cases, identify gaps in care, and address barriers to access for transitioning members.
Timely and Accurate Information	Our care management system, Health Intech, combines data and information from various sources into a single record comprising a holistic and longitudinal picture of the member's utilization, care management, and gaps in care. It includes the member's Care Needs Screening (CNS), comprehensive assessment, care plans, longitudinal member health records, and clinical data for providers to transfer information.
Care Managers	During the initial CNS and comprehensive assessment (as indicated or needed), our community-based Care Managers (CMs) will take time to learn about members' preferences, family, and supports to identify and understand care needs and maintain continuity of care throughout periods of transition.

Promoting Continuity of Care Through Coordinated Transitions — MCO

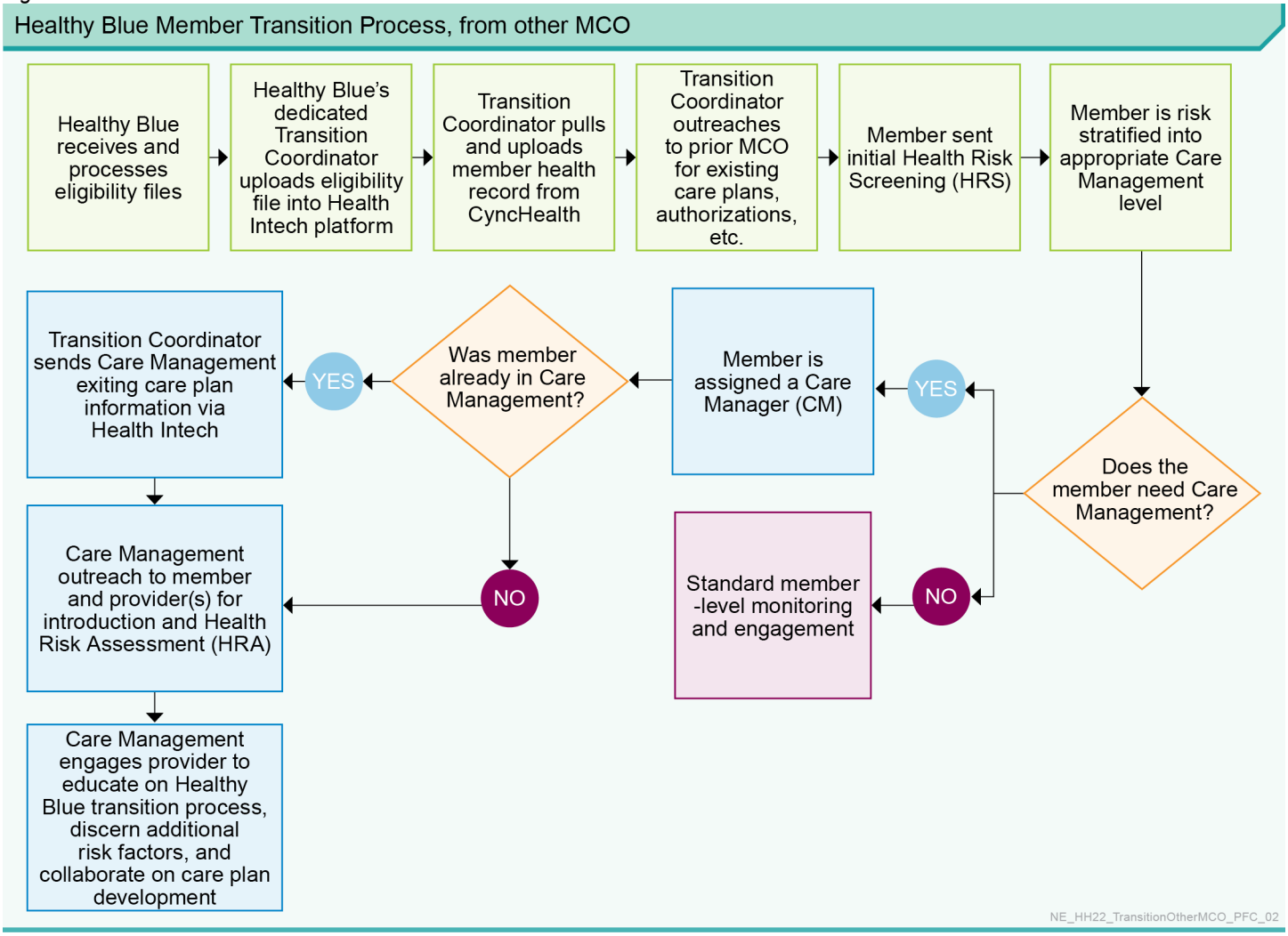
Healthy Blue's effective continuity of care processes assure all transitions are well-coordinated. We understand continuity of care is imperative and incorporate this in our policies and procedures to make sure members' current services and their providers remain available during transition.

The member health record is reviewed and uploaded from CyncHealth. Our Care Management team works with the other MCO to receive a clinical summary of information to include:

- The member's care plan, when applicable.
- A listing of prior authorized services and medication summary.
- The member's PCP, Advanced Medical Home (AMH), Local Health Departments (LHDs), or other specialty provider's contact information and treatment plan summary.

Our Care Management team will also immediately outreach to the member and establish a positive relationship upon transition. Figure V.X.112-1 shows how we will seamlessly transition the member from another MCO.

Figure V.X.112-1. Seamless and Scalable MCO Transitions.



Promoting Continuity of Care Through Coordinated Transitions — FFS

Healthy Blue will pay out-of-network (OON) providers at 100% of the Medicaid FFS rate, to support member continuity of care. (SOW Q.9.d). In addition to working with other MCOs and the state, our dedicated Transition Cooordinator also references Cync Health, Nebraska's health information exchange, which contains member information necessary for transitions. If immediate action is identified during these reviews, a dedicated CM is assigned to assist as well.

We support continuity of care during transitions between MCOs, service delivery systems (FFS to managed care), and across levels of care (for example, transitioning during an inpatient stay). We honor PAs for newly enrolled members for at least 90 days including services provided by OON providers. Additionally, we cover hospital services for 60 days or until the member is discharged, whichever is less. Our Care Management team coordinates these transitions by working closely with other MCOs, FFS Medicaid, and community-based support systems.

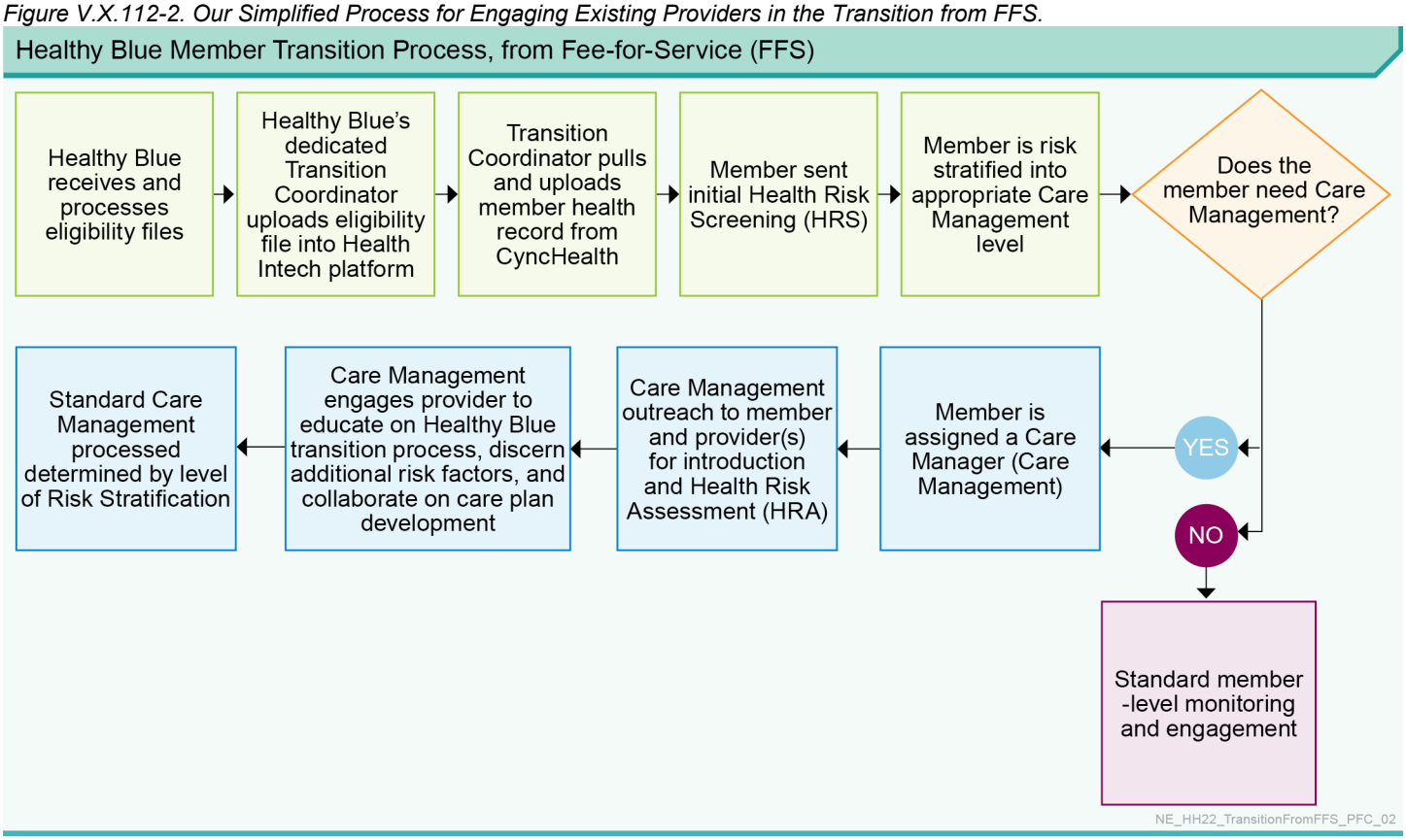
As mentioned previously, upon enrollment into our plan, our Care Management team works to proactively identify members at high risk, members with specialized needs and conditions, and those who have pre-existing care plans, authorizations, and services. We then contact the member's circle of support, as identified by the member, which may include friends, caregivers, family, and guardians, the member's providers, and the PCP to assess the member's prescribed treatment plan and services, including the need for care management. For high-risk members, we will employ a boots on the ground model, including face-to-face visits.

Additionally, we review and load any care plan, PA, or assessment information received from FFS providers or the member's prior MCO into our Health Intech platform. We work with counterparts at other MCOs and FFS case managers when applicable, to verify we have complete information about the member's prior authorized services so there is no interruption in care or services. When necessary, Utilization Management (UM) staff create new authorizations to assure continued access to services. If a member is receiving a service that did not require PA by the previous MCO, but requires a PA from Healthy Blue, we create this authorization to **assure uninterrupted care.** Whenever possible, our CMs work with the Care Management teams from other MCOs to ensure effective communication to streamline provision of needed documents.

We value consistency of care. Therefore, we will continue the services included in the member's previous care plan until the member has completed all applicable assessments to identify and implement the appropriate change to the level of service. The care plan will

then be updated to address gaps and opportunities to elevate the care delivered. Healthy Blue assesses members transitioning into the plan without an existing care plan and if identified for engagement in care management, the CM initiates care plan development. Figure V.X.112-2 demonstrates our simplified and streamlined process for this type of transition.

Figure V.X.112-2. Our Simplified Process for Engaging Existing Providers in the Transition from FFS.



A dedicated Transition of Care Manager receives a file monthly with all members transitioning from other MCOs and from FFS programs. Providing coordination, collaboration, oversight as appropriate, and information sharing with PCMHs, LHDs, CMS, and community-based providers as needed. Through early identification, assessment, and care plan development, Healthy Blue transitions Nebraskans seamlessly — informing them through department-approved welcome materials and outreach efforts, and conducting follow-up welcome calls to identify immediate or existing health care needs.

Promoting Continuity of Care During Provider Transitions

Promoting and supporting provider communication and coordination is a critical function at Healthy Blue. Steps are taken within our plan and across MCOs to support and facilitate bi-directional communication and automated information sharing between providers to promote integrated physical health and BH care. In turn, members do not experience a gap in care during a transition with us. We encourage and work with providers to:

- **Facilitate Exchange of Information.** Collaborate with Nebraska providers to share medical records with us via an automated process.
- **Promote Provider Coordination of Care.** Encourage providers to communicate clinical findings, treatment plans, prognoses, and psychosocial conditions.
- **Encourage Communication Among Providers.** Require network providers to document activities in members' health records and share information.
- **Honor Pre-existing Care Plans.** Review existing member care plans to identify and incorporate any continuity of care needs, such as existing PAs.
- **Expedite Continued Care.** Authorize continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner.

Healthy Blue coordinates care among BH providers, PCPs, specialty providers, and external case managers. We take every effort possible to keep high-quality providers in our network; however, if a termination occurs, we assure a smooth transition for our members, as shown in Figure V.X.112-3.

Figure V.X.112-3. We Make Sure That Members Experience a Smooth Transition During Provider Terminations.

Assuring Smooth Transitions for Our Members During Provider Terminations

- **Communicating with Providers.** After creating a Work Plan, the assigned Project Manager schedules mandatory internal transition meetings with the provider; coordinates the drafting and finalization of applicable communications through internal communication management processes; and notifies and trains staff to support the Work Plan.
- **Identifying Impacted Members.** The Project Manager utilizes recent utilization data to identify all members assigned to or visiting providers within the exiting group or health system, as well as what services they were receiving from the provider group to assure continuity of care.
- **Notifying Impacted Members.** We notify each member who received care from the provider within the last 18 months through first-class mail within 30 days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination. We provide written notice to members who have been receiving prior authorized treatment within 10 calendar days of the date Healthy Blue becomes aware of the termination. The notice includes a pre-paid envelope and explains the process to select another provider. We supplement notifications with FAQs on our member portal and mobile app, and automated outbound calls. Additionally, we personally reach out by phone to notify each affected member of the change and help them find a new provider. We also let members know that medically necessary care from that provider may continue through completion of treatment or until the member selects another treating provider, up to 90 days or until the member is reasonably transferred without interruption of care.
- **Assisting Members with Identifying New Providers.** Members can change providers through multiple options. They may call our Member Services Call Center or change providers on our website. For members who do not select a new PCP, we utilize a PCP auto-assignment algorithm and member default optimization process and notify these members of their new PCP. Healthy Blue Care Managers (CMs) reach out to members engaged in CM to directly assist in finding a new provider, developing a transition plan, and alleviating any member concerns. For members not engaged in CM, our Transitions of Care (TOC) team contacts and engages them to assist the member as needed to make sure the member has a positive transition process and a coordinated transition plan.
- **Assuring Continuity of Care.** For members in active care at the time of a provider transition, CMs work with members involved in care management to develop a transition plan and alleviate any member concerns. For members not engaged in care management, our TOC team contacts and engages them to assist the member as needed to make sure the member has a positive transition process and a coordinated transition plan.

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Out-of-network Providers

If member is in active treatment with an OON provider, we establish an SCA with our Provider Services team to make sure we continue services and attempt to recruit the provider into our network. We educate OON providers, and any new providers on Healthy Blue's billing and PA policies and procedures. We also share information about member needs and service gaps through secure email to promote timely access to needed care and services. For members who do not require immediate care, we conduct the Health Risk Screening, as required for all members entering the plan and referred to programs as applicable.

Members Receiving BH Services

When a member is receiving BH services at the time of enrollment with Healthy Blue, we immediately assign a CM who works closely with any external case manager, the BH provider, and the member's PCP to ensure a smooth transition, with a focus on continued service authorization — including access to current medications and development of a comprehensive and coordinated care plan specific to the member's needs and level of care.The transition staff work closely with the member's previous MCO, program administrator, and/or providers to connect members receiving BH services who are new to Healthy Blue or transitioning to another MCO with a CM who monitors their care, comprehensive health assessment, stratification, and care coordination process. When a member with a BH condition enters or leaves Healthy Blue, the CM works closely with any other CM who has worked or will work with the member as well, as any provider or facility to coordinate services. With the member's permission, we share pertinent assessments, recovery plans, crisis plans, medication histories, and up-to-date laboratory studies. As needed and with member consent, the CM remains available to assist after the member leaves our plan.

Our integrated Care Management teams assist the member in selecting an in-network BH provider in their service area that is the best fit for their needs. If a network provider is not available to render needed services, we help the member locate an appropriate OON provider and work with that provider to establish an SCA. The CM also assists with transferring records to the new provider, sharing the member's care plan if applicable and consent provided, assisting the member with appointment scheduling as needed, and providing other necessary support services. The CM works with the member and OON provider to determine how long the member may continue to receive OON services based on the member's specific needs, until we are able to identify a qualified in-network provider.

Establishing and Implementing Procedures

Our CMs in every focus area, such as BH, OB, and physical health, collaborate closely with UM staff and Medical Directors to coordinate care for members as they transition in and out of the program, across MCOs, among providers, and across care settings including discharge planning for all hospital and institutional stays. Healthy Blue maintains policies and procedures that adhere to the requirements in the SOW while making sure members have access to prior authorized services following a transition from another MCO or other service delivery system such as FFS. Our policies and procedures outline the following:

- Appropriate support to CMs, and to members and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation or other service supports
- Determination of the need for non-covered services and referral of the member for assessment and referral to the appropriate service setting with assistance, as needed, by the State

- Transfer of medical/case records in compliance with HIPAA privacy and security rules
- Documentation of referral services in enrollee medical/case records, including follow-up resulting from the referral
- Monitoring of members with comorbidities and complex medical conditions and coordination of services for high utilization of health care services to identify gaps in services and evaluate effectiveness of case management
- Identification of members with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and develop actions to reduce avoidable emergency department visits and potentially avoidable hospital admissions
- Transitional care management that includes coordination of hospital/institutional discharge planning and post-discharge care (conducting a comprehensive assessment of member and family caregiver needs, coordinating the patient's discharge plan with the family and hospital provider team, collaborating with the hospital or institution's staff to implement the plan in the patient's home and facilitating communication and the transition to community providers and services)
- Reporting requirements for nursing facility transition, including reporting schedules for case management and submission to the State on a quarterly basis
- Privacy protection during coordination of care that complies with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164, particularly identifiable health information

Continuity and Coordination of Care

Healthy Blue's core mission is to provide high-quality care that improves our members' well-being as well as enhance population health outcomes for the communities we serve. To achieve this goal, we adopted a culture of quality that is integrated into every element of our operations. Our efforts are supported by our comprehensive, systematic, data-driven Quality Assessment and Performance Improvement (QAPI) program. QAPI helps to improve medical care coordination by analyzing data on care transitions between practitioners and across settings. Actions are taken on opportunities identified and the effectiveness of actions are measured

To assist in the transition of members from one level of care to another, Healthy Blue recommends transition meetings or appointments are held prior to the member moving from higher to lower restrictive levels of care or vice versa to assure continuity of treatment. We encourage providers to include our CMs in these meetings and appointments.

The scope of continuity and coordination of care activities includes assessing for timely coordination of care post facility discharge, the appropriate transition of members from one level of care to another, and medical record documentation that reflects the presence of the consultant's notes, as appropriate. Other activities include assisting a member's transition to other care when benefits end or assisting members to transition from pediatric care to adult care when they reach adulthood. Healthy Blue provides continuity and coordination of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. We make sure that the appropriate people, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems as it relates to continuity and coordination of care. Our experience and proven methods will assure continuity of care activities are effective and consistent.

Transitions During Inpatient and Residentials Stays

At times, some members experience transitions between MCOs during hospitalizations or while receiving care in alternate care settings. Due to the elevated stress for the member and the uniqueness of the situation, we want to ensure a seamless transition for the member. If the member is transitioning in or out of our plan, we effectively communicate with the hospital facility to ensure clarity in understanding financial responsibility (ours or theirs) to the member's services. We provide the member's new MCO with a clinical summary that includes:

- The member's care plan including social supports
- Prior authorized services
- Inpatient hospital utilization history
- Medication summary
- Comprehensive provider listing to include the PCP and BH providers

Coordination with Community-based Organizations

Continuation of support from community-based organizations is vital during transitions and could mean the difference between getting meals, transportation, or other important social and health care needs met. We will not allow transitions in coverage to be a root cause that widens gaps in disparity. Therefore, our team's ability to effectively bridge the gap and prevent disparity is a top priority for our CMs. Next, we provide a member story, in Figure V.X.112-4 that proves our commitment and hands-on approach.

Figure V.X.112-4. Healthy Blue Collaborates with Community-based Orginizations.

REAL STORIES

A **quadriplegic member** needed help transitioning from a rehab facility. The member qualified for the Waiver program and Healthy Blue's CM worked with the personal legal representative (member's mother) to streamline the application process prior to discharge. Our teams worked with the Waiver program staff and the local League of Human Dignity to help with modifications needed in the home, respite care, and primary caregiver pay. Temporary equipment was provided until the specially ordered items were available. Equipment included a hospital bed, shower chair, and hoyer lift. The Healthy Blue dedicated CM also called two local churches (while keeping with HIPAA regulations) that were willing to help the member and her family with yard work, meals, and attending group events and service. The churches' contacts were emailed to member's mother, along with telehealth counselors and an explanation of benefits, including Healthy Blue's value-added services list. The CM also met face-to-face with the member and her mother to explain the benefits, answer any questions, and encourage them to call member services should any new questions arise. The outreach and communication with our dedicated CM is continuous with member and family support system to assess for any further needs/concerns. Members may contact their dedicated CM directly anytime.

NE_HH22_Quadriplegia_Q112_RS_02

No. 113

Our parent company, Elevance Health, Inc. (previously known as Anthem, Inc.) has worked in several states with other MCOs and key provider stakeholders to align to a common Electronic Visit Verification (EVV) vendor and has experience with the various models of EVV programs. As such, we understand the value a common vendor can offer in establishing consistent requirements, common file exchanges, role-based access, streamlined training supports, and other resources for both members and providers. Our parent company has extensive experience with EVV and a track record of fulfilling CMS requirements with the 21st Century Cures Act. Leveraging our parent company's experience in working with State partners and other MCOs, we understand and agree to align to a common EVV vendor, which will help to reduce administrative burden and improve service delivery.

Example from Prior Experience

Our affiliate in Iowa collaborated with other MCOs to vet several EVV vendors. After an EVV vendor was selected through this collaborative process, the Iowa team met with the State representatives and the vendor to identify goals and define requirements around specified codes sets, pilot approaches to rollout, timing, and hard edits. Following this work, the MCOs, EVV vendor, and the State worked collaboratively with providers to share the identified goals and requirements. We attended numerous provider forums, providing information, obtaining feedback, addressing concerns, and driving ongoing collaboration and communication. Each MCO entered into individual contracts with the selected EVV vendor and followed their own internal processes for establishing file exchanges, testing, and other requirements. Providers chose the electronic methods they would use for EVV, establishing the review of manual entries and confirming the submission of EVV within the vendor system that then initiated the claim file. The EVV vendor tied the visit to the authorization and eligibility check, aligning it to the individual's patient-centered care plan (if applicable). Additionally, the vendor applied any established requirements/edits, then submitted the claim (837 file) to the MCO's Electronic Data Interchange (EDI) platform so that the claim could be processed accordingly. The EVV received a claim payment confirmation file (835 file) as reconciliation within their system. The system was designed so that providers would have access to this information in the EVV vendors system as well as the MCO's EDI platform. EVV patterns are reviewed proactively to identify opportunities to work with providers for additional education and technical assistance.

Additionally, the Long-Term Services and Supports Service Coordinators (SCs) in our Iowa affiliate leverage EVV information to follow up on missed visits and verify service initiation as appropriate based on the services/supports. When a missed visit occurs, the SC outreaches to the member to assure their back up plan for supports is in place. The SC works with the individual to coordinate backup coverage. For individuals that are self-directing their services, the Fiscal Intermediary also uses the MCO-selected EVV vendor, allowing agency providers to use a single system for their workforce.

In Iowa, more than 214 provider agencies, 1,400 Director Support Workers (non-fiscal intermediary) and 630 Self Direction Direct Support Workers (Fiscal Intermediary) are using EVV. The mobile application is the number one check-in and check-out method across the board. With its ease of use and on-the-go functionality, use of the mobile application continues to grow.

With more than 15 years' experience with EVV, we will leverage best practices such as those described in the previous example, from our affiliate health plans in Texas, Iowa, Tennessee, Florida, Virginia, and New Jersey, to support our work with the other MCOs to secure a vendor and exceed the State's expectation on the obligation of executing a best-in-class program.

No. 114

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Fostering Community Partnerships for Chronic Illnesses

Healthy Blue and The Nebraska AIDS Project (NAP) have collaborated to promote HIV awareness and increase HIV testing and education across Nebraska.

Technical Approach Attachments

Healthy Blue

CALLED TO CARE - Cathy Johnson, Care Manager

Working in Medicaid for the past 6 years, I focus on making a difference. When I can help members find a service or a resource that truly makes their lives better, I am exhilarated! Recently, I was speaking with a special needs member's mom and I could tell that she felt isolated and alone. I let her know that I understood and she opened up to me; that, in itself, made a difference to her. After some discussion, I gave her information on a family organization in her area that she didn't know existed. She said that was exactly what she needed and she was very grateful.

CALLED TO CARE: My own personal experience with Medicaid is why I love working in managed care. My first child was diagnosed with Autism Spectrum at 3 years old; by then I had 3 children and financial issues pushing me into depression. Light came into my life when helpers entered introducing me to available community resources including a housing program, food stamps, Title 20, and Medicaid. My son's diagnosis increased to include ODD, ADHD, and bipolar disorder. My heart dropped the day I received a bill for $90,000 that my son's primary insurance hadn't paid. I will be forever grateful to Medicaid for paying that bill and many bills for his care. Thanks to Medicaid, my son graduated high school, is living on his own, and works in the school system. This is really why I do this work, so other families can have the same success my family experienced.

Attachment V.C.8-1: Certificate of Authority

Healthy Blue

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

COMMUNITY CARE HEALTH PLAN OF NEBRASKA, INC.

DOMICILED IN THE STATE OF NEBRASKA

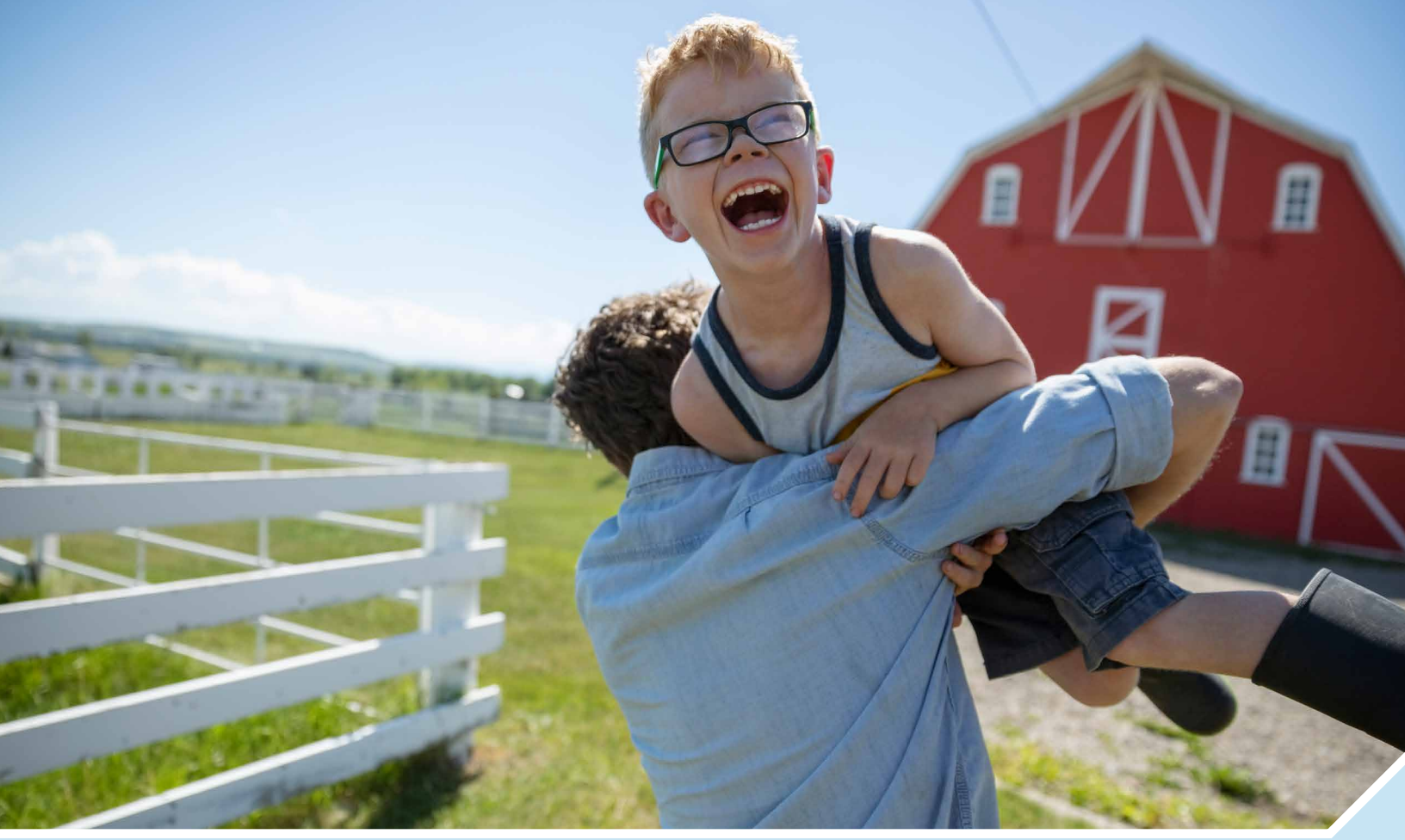
IS HEREBY AUTHORIZED AND LICENSED IN NEBRASKA TO TRANSACT THE BUSINESS AS A HEALTH MAINTENANCE ORGANIZATION (HMO) IN THE STATE OF NEBRASKA AS DESCRIBED BY CHAPTER 44 OF THE INSURANCE STATUTES OF NEBRASKA:

59227800	May 01, 2022	April 30, 2023
NEBRASKA IDENTIFICATION NUMBER	**DATE ISSUED**	**DATE EXPIRES**

SIGNED AT LINCOLN, NEBRASKA

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1ST 1867

DIRECTOR OF INSURANCE



Supporting Children in Foster Care

Healthy Blue helps sponsor The Foster Care Closet, which provides clothing and resources for children in foster care throughout the state.

Attachment V.I.30-1: Examples of Member Services and Education Materials

Healthy Blue

Attachment V.I.30-1: Examples of Member Services and Education Materials

Attachment V.I.30-1 includes the following:

- V.I.30-1a: Child Adolescent Behavioral Health Flier
- V.I.30-1b: EPSDT Well-Child Visit Reminder
- V.I.30-1c: Preeclampsia Action Plan
- V.I.30-1d: Member Education Social Media Examples

Healthy Blue

HERITAGE HEALTH

How can you support your child in a crisis?

Children and teens can face **personal, social and school pressures every day.** Those living with behavioral health conditions are more likely to have a tough time and may think about taking their own lives.

Warning signs that a person is thinking about suicide

- Talking about suicide, death or "going away"
- Giving away personal items
- Talking about feeling hopeless, sad or depressed
- Staying away from friends, family, activities
- Having trouble thinking clearly
- Changes in eating or sleeping habits
- Taking part in risky behavior (drinking alcohol, taking drugs, self-harm)

Some children may try to escape bullying, feelings of rejection, hurt or loss. They may also feel:

Angry, ashamed or a general sense of guilt.

Helpless, unloved, unwanted or a burden to others.

Down on themselves.

Worthless.

Asking for help is a sign of strength for those facing a crisis. As a parent, guardian or loved one of someone in crisis, **it's okay if you need to reach out for help, too.**

BNE-MEM-0241-20

healthybluene.com

11 01 2021

How can I help?

Talk with your child about suicidal thoughts or plans they may have. Be open and honest with each other. It's okay that it's a hard subject to talk about.

Listen. Show that you care about what they're going through.

Take action to keep them safe. Keep any firearms, drugs (and prescriptions) or other means of suicide out of their way and properly locked.

Stay with them. If you feel they might harm themselves, don't leave them alone and get help right away.

Get help now.

- Call the National Suicide Prevention Lifeline at 800-273-TALK (8255).
- Text HOME to 741741 to reach the Crisis Text Line to text with a trained Crisis Counselor.
- Call the TrevorLifeline at 866-488-7386. The Trevor Project offers crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer & questioning (LGBTQ) youth.
- Always call 911 in an emergency or go to the nearest emergency room even if it's not in Healthy Blue's network.

To learn more, go to healthybluene.com.

Choose *Health & Wellness* to find behavioral health tools and resources to help those living with depression and other health conditions.

Helpful Phone Numbers for Healthy Blue members only:

Member Services:
833-388-1405 (TTY 711)
Monday through Friday from 8 a.m. to 5 p.m. Central time

24-Hour Nurse Help Line:
833-388-1405 (TTY 711)

Sources:
National Institute of Mental Health, Suicide Prevention
nimh.nih.gov

Well-Child Checkups and Immunizations

Healthy Blue is here to help your child get a healthy start in life. That is why we want to remind you your child is due for a well-child checkup. Your child's doctor or primary care provider is listed on your child's Healthy Blue ID card. Please call and make an appointment today. Well-child checkups and immunizations help keep your child healthy.

Do you want help making an appointment or need a ride to the doctor? If so, please call Member Services at 833-388-1405 Monday through Friday from 8 a.m. to 5 p.m. Central time. Members who are deaf or hard of hearing can call 711.

What Parents Need to Know about Lead

Lead is harmful to children. It can be found in soil, air, water, some toys, and old paint. Too much lead in the body can make children sick. This is called lead poisoning. Your child's doctor can do a blood lead test. This is the only way to know if your child has lead poisoning. Help your child grow up healthy! Call your child's doctor at the number listed on the front of your child's Healthy Blue ID card to have your child tested today.

Car Seat Safety

Car crashes are the #1 killer for kids under the age of 14. To help make car rides safer for them:

- Buckle up your kids every time.
- Make sure the car seat is put in properly.
- Use a forward facing seat for children 1 year of age or older who weigh over 20 pounds.
- Use a booster seat for school-age children up to age 8.
- Have children 12 years of age or younger ride in the back seat.

Time for Your Child's Checkup!

Your child's birthday will be here soon. Healthy Blue would like to be the first to say happy birthday!

Please use the well-child chart in this mailer to see what services are now due for:

Healthy Blue | HERITAGE HEALTH

ATTENTION: Quality Management
Post Office Box 62509
Virginia Beach, Virginia 23466

PRSRT STD
U.S. POSTAGE
PAID
NORFOLK, VA
PERMIT #427

To the parent or guardian of:
Para el padre, la madre o el tutor de:

BNE-MEM-0093-20 12 19 20

Healthy Blue | HERITAGE HEALTH

Your Healthy Blue

preeclampsia action plan

Healthy Blue

HERITAGE HEALTH

Have your doctor complete the information on the other side of the action plan. You can also write your blood pressures (BP) on the back.

Green zone: No symptoms	Yellow zone: Call doctor	Red zone: Get medical help now
❑ BP within normal range ❑ No headaches ❑ No vision changes ❑ No shortness of breath ❑ No right upper belly pain ❑ No weight gain of 2 pounds in a day or 5 pounds in a week ❑ No swelling in face, arms, or legs ❑ Tolerating food and fluids	❑ BP at or above by doctor's orders ❑ Frequent headache(s) or new headache(s) ❑ Vision changes: seeing spots, blurry vision, etc. ❑ Swelling in your face, hands, or feet ❑ Weight gain of 5 pounds in a week ❑ Pain in belly, nausea, or vomiting	❑ Daily headaches that won't stop after taking medicine ❑ Blurry vision or loss of vision ❑ Hard time breathing or catching breath (laying down or sitting up) ❑ Right upper belly pain that won't go away ❑ Nausea, vomiting, or heartburn that won't stop after taking medicine ❑ Chest pain (laying down or sitting up) ❑ Swelling in face, hands, arms, or legs that gets worse and causes color or skin temperature changes ❑ One leg more swollen than the other and skin temperature differences ❑ Decrease in urination
Action	**Action**	**Action**
• Continue taking medicine per doctor's orders. • Go to prenatal visits. • Check BP per doctor's orders. • Weigh self if instructed by doctor. • Stop smoking, drugs, alcohol, and caffeine. • Follow diet plan if ordered by doctor. • Continue with daily activities.	• Call doctor's office for update on treatment plan. • If you need an appointment, someone should take you. **DO NOT DRIVE YOURSELF**.	• If having one or more symptoms, call your doctor now. • If you are alone and need to call for help, call 911. • You may need immediate medical attention. **DO NOT DRIVE YOURSELF.** CALL 911

BNE-MEM-0068-20 01 08 2021

Name: _____

Doctor: _____

Office phone number: _____

*After-hours office phone number: _____

Blood pressure (BP) range set by my doctor: _____

Top number higher than: ≥ _____ **or** Bottom number higher than: ≥ _____

Emergency contact name and phone number: _____

Date	Time	BP	BP recheck	Weight (lbs)	Orders from my doctor

*If doctor's office is closed, call after-hours phone number for assistance.

Healthy Blue Nebraska Member Education Examples – Social Media

Healthy Blue Nebraska
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When you or your child is sick or injured, you want to get care as soon as possible. Visit our Getting Care 24/7 page for some guidance on when to go to your PCP, an urgent care center, or the emergency room. http://bit.ly/3p2eFKo

Healthy Blue Nebraska
Insurance Company
LEARN MORE

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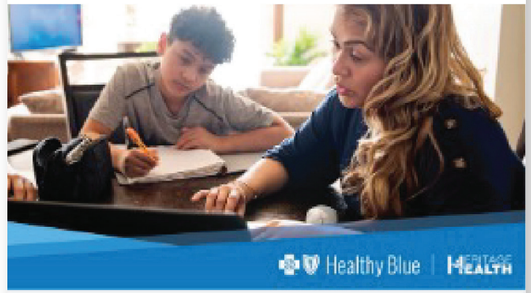
Need a doctor for your child? It's important for you to find someone you and your child trust and feel comfortable visiting. Follow these simple steps to help you find the right pediatrician/doctor.

HEALTHYBLUEBLOG.COM
Choosing the right doctor for your child - Healthy Bl....
LEARN MORE

Healthy Blue Nebraska
Sponsored •

Q: Should healthy kids still go for checkups?
A: Yes, kids should continue to go for in-person checkups, even if they are healthy. During a checkup, healthy children will receive vaccines to prevent common illnesses and help strengthen their immune systems.



HEALTHYBLUEBLOG.COM
Do kids still need their shots during COVID-19? - Health..
LEARN MORE

Healthy Blue Nebraska
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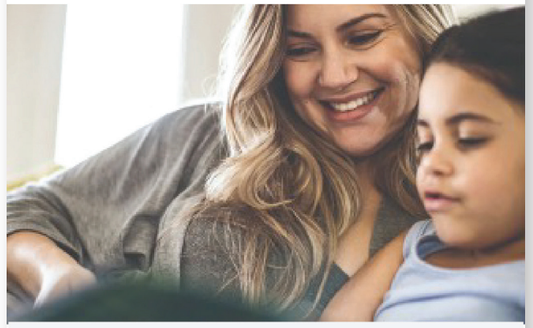
Expect more from your Nebraska Medicaid health plan. With Healthy Blue, you're covered for doctor visits, prescriptions, and immunizations. Plus added, no-cost benefits to help you live a healthy life. See everything we cover: https://bit.ly/3jY0H8V



CHOOSEHEALTHYBLUE.COM
Healthy Blue Nebraska
LEARN MORE

Healthy Blue Nebraska
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Our Community Resource Link makes it easier to find local mental wellness resources during COVID. Find support groups, peer recovery coaching and one-on-one resources near you. https://bit.ly/3cFPFWo

Healthy Blue Nebraska
Insurance Company
LEARN MORE

Healthy Blue Nebraska
Sponsored •

Childhood vaccines are an essential part of keeping your kids healthy - both now and as they grow up! Find out more about staying on track with your kid's vaccinations.

HEALTHYBLUEBLOG.COM
Now is a great time to take your child for their well...
LEARN MORE

Healthy Blue Nebraska
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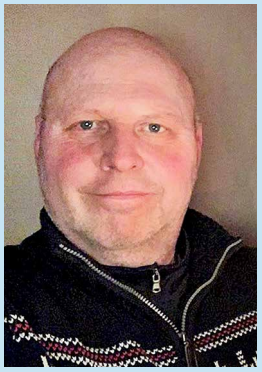
Find care when you need it. Live chat for answers to your questions. Order prescriptions. All this and more. All in your hands.

MEMBER.HEALTHYBLUENE.COM
Activate your account
SIGN UP



CALLED TO CARE - Sean Martin, Provider Network Manager Senior

I grew up in Omaha, Nebraska and I have worked in Medicaid for the past 7 years. My goal is to work with providers to improve the quality of care for members while reducing costs. As part of a special project, I made check-in calls to members over 65 to see if they had any pain or mobility issues and if they had a support team. I was saddened to hear how many were struggling and had no one to go to for help. One of our case workers helped them sign up for the elderly waiver to get the needed services. I was happy to get meals delivered and other services to improve their lives. Our members were very grateful that they had a managed care company that actually cared about their well-being.

CALLED TO CARE: I was motivated to get into managed care when one sister-in-law was diagnosed with breast cancer and the other was diagnosed with juvenile diabetes. They both had insurance, but I saw what a treatment and cost burden getting care for their conditions was on the family. I determined to do whatever I could to improve the quality of healthcare and reduce the cost. My family is very dedicated to making a difference in the health and well-being of others.

Attachment V.I.33-1:
Plan for Developing an Adequate Network

Healthy Blue

Attachment V.I.33-1: Plan for Developing an Adequate Network

Attachment V.I.33-1 includes the following:

- V.I.33-1a: Healthy Blue Network Development Work Plan
- V.I.33-1b: Liberty Dental Network Development Work Plan

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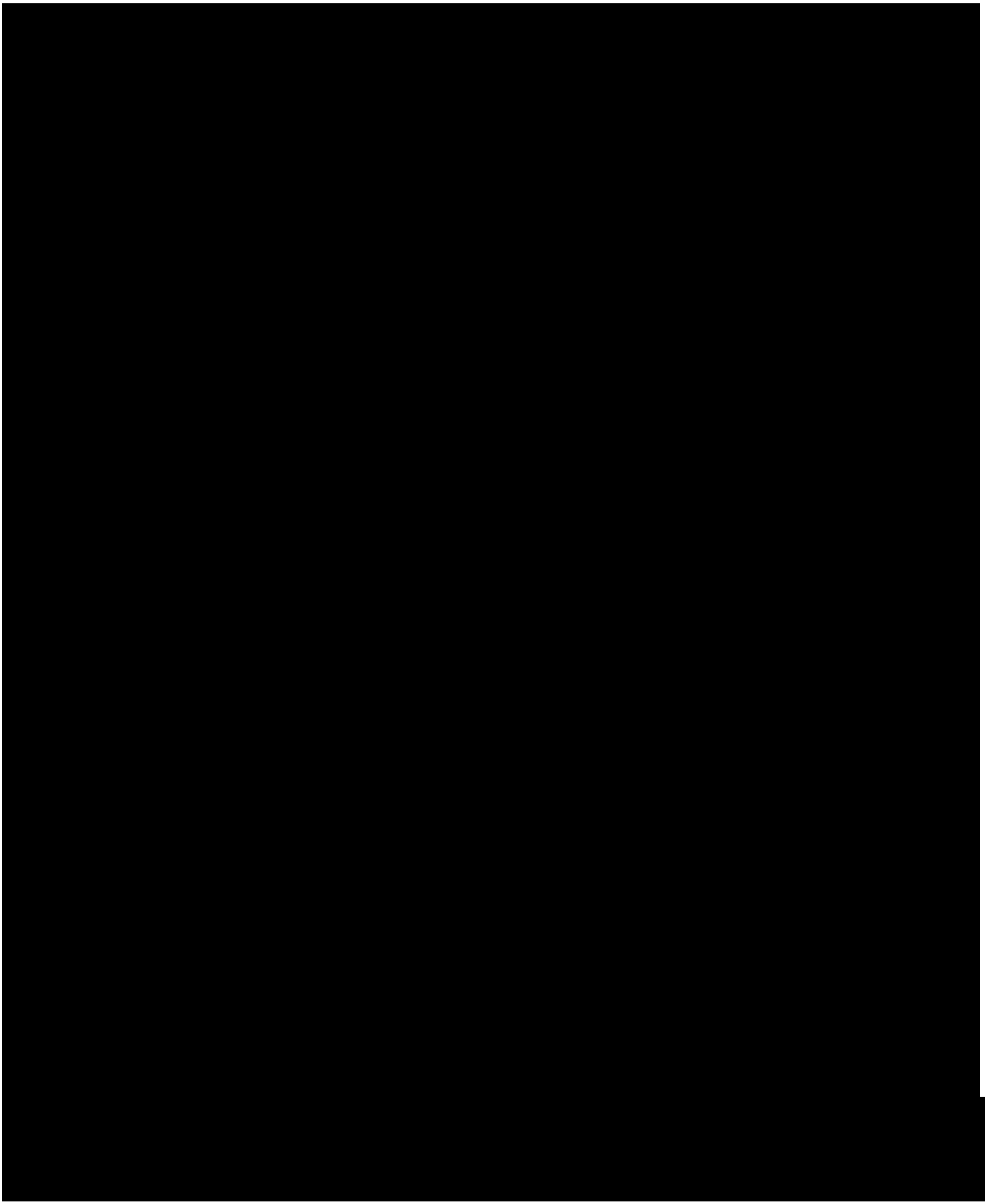

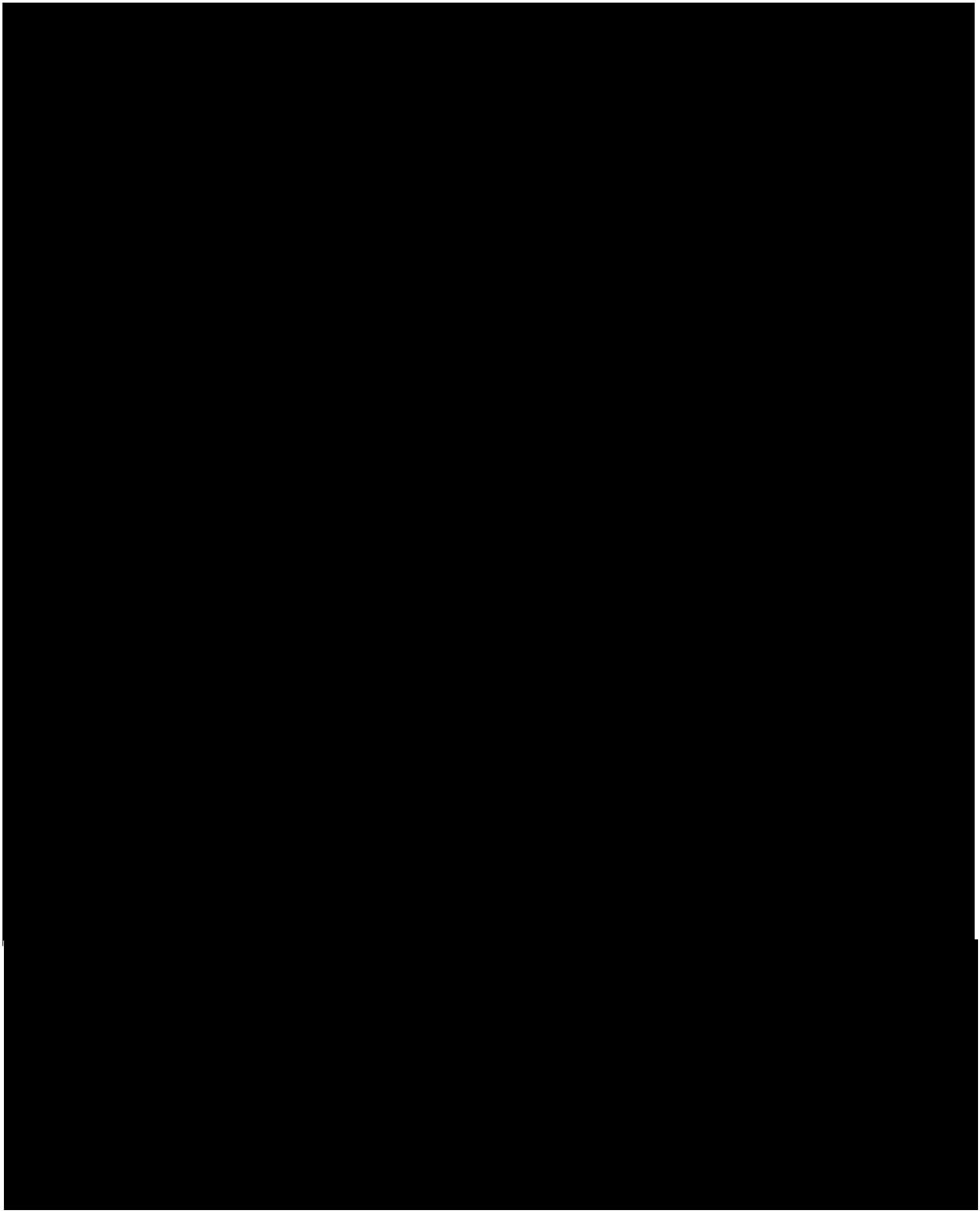

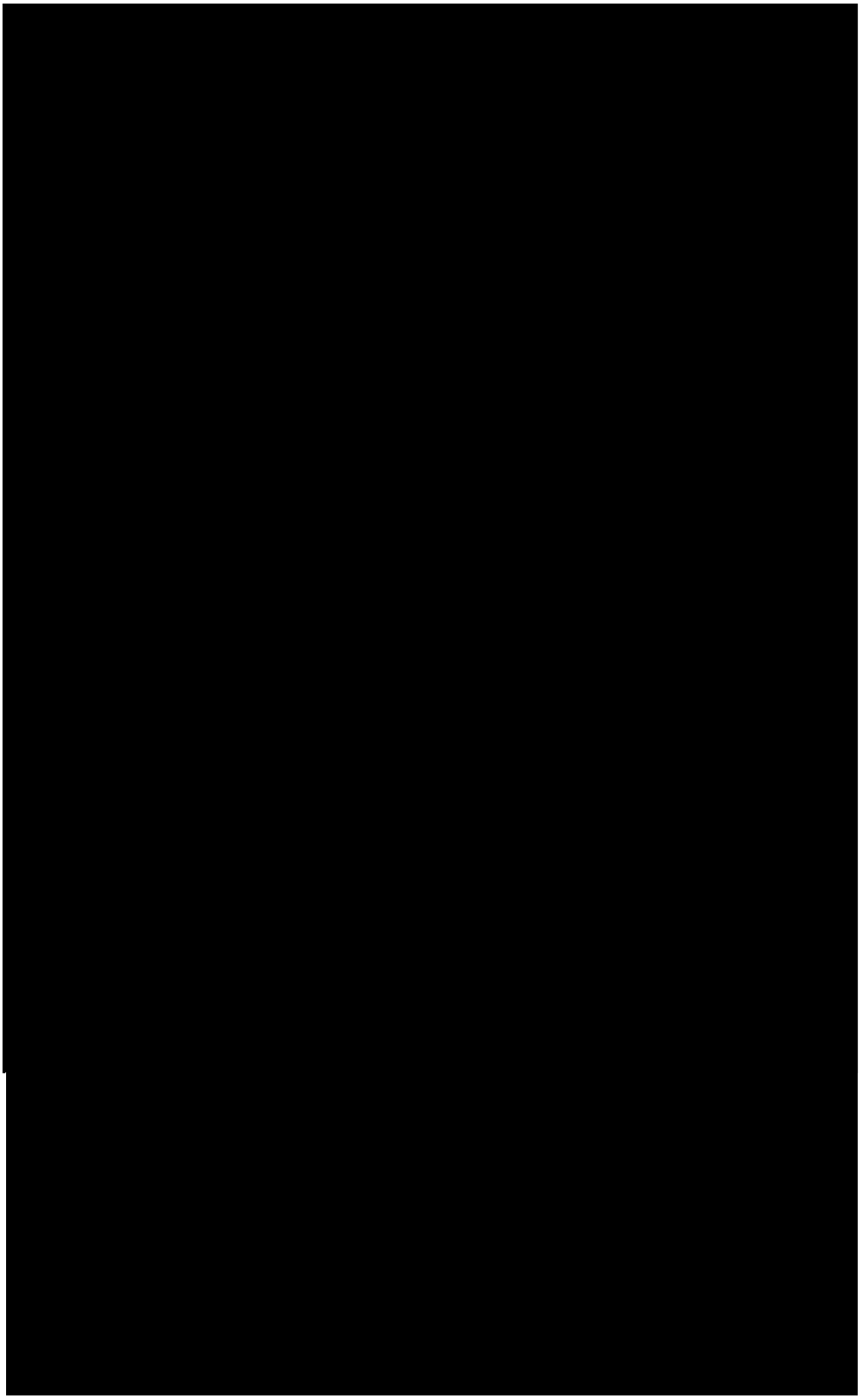

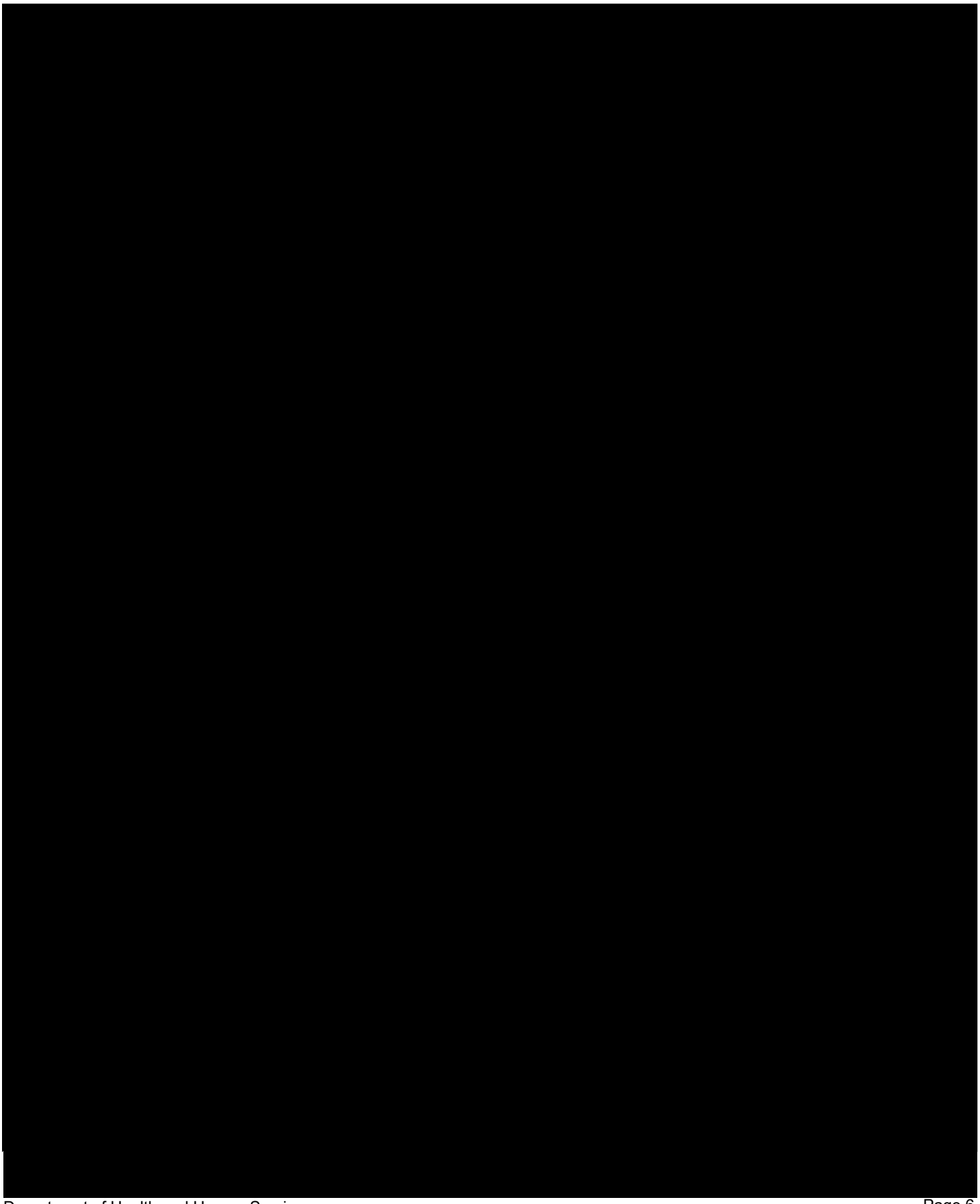

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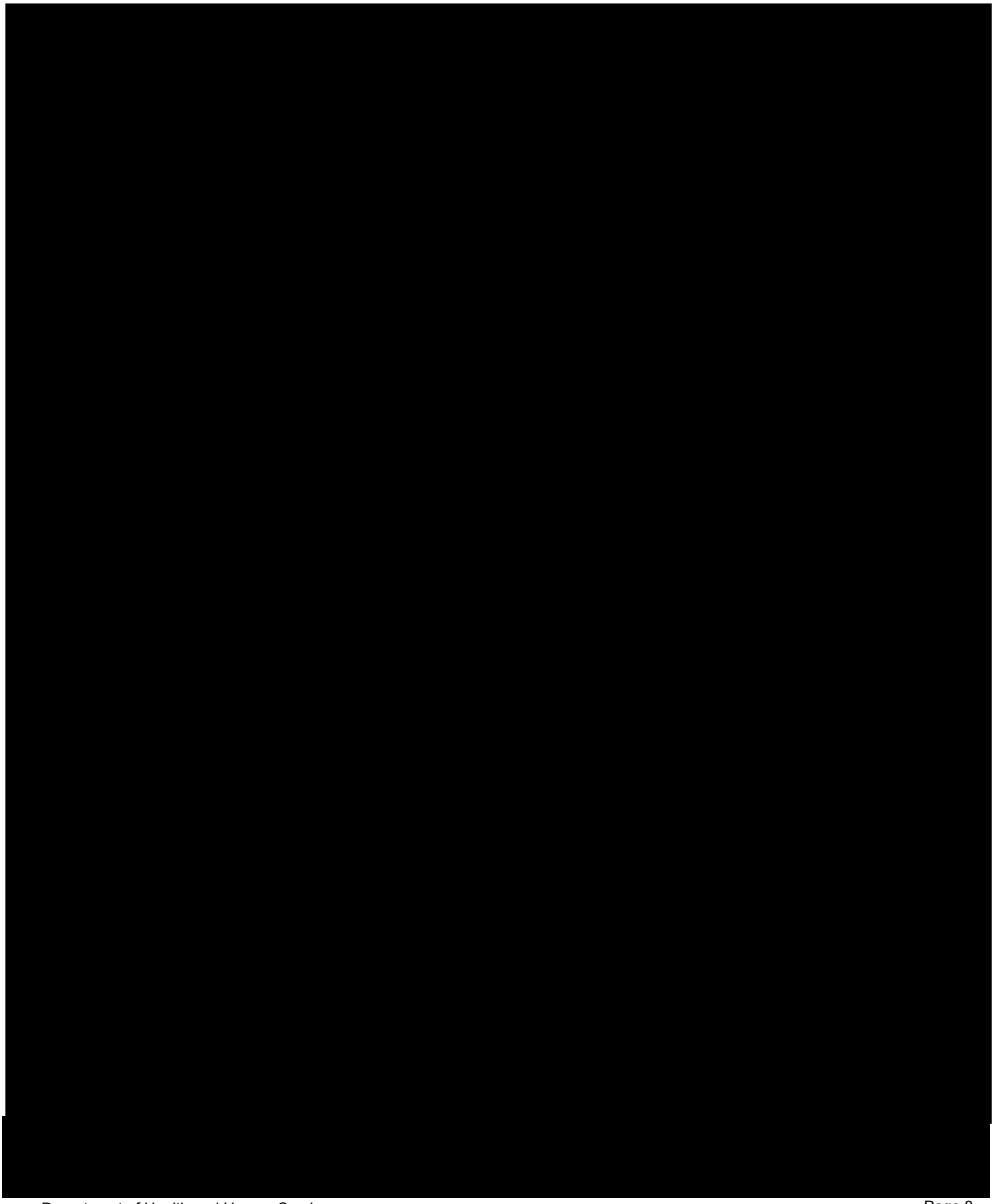

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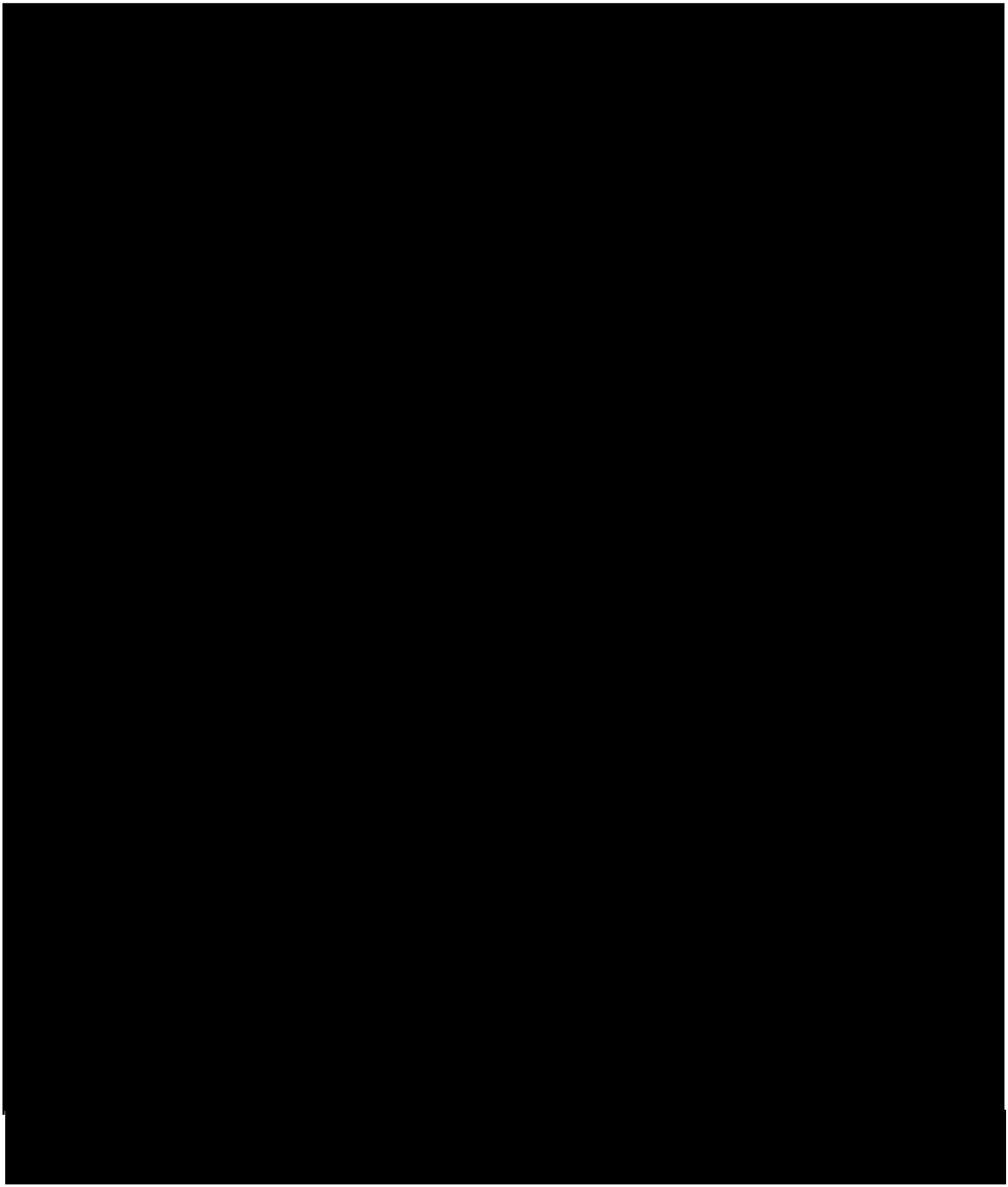

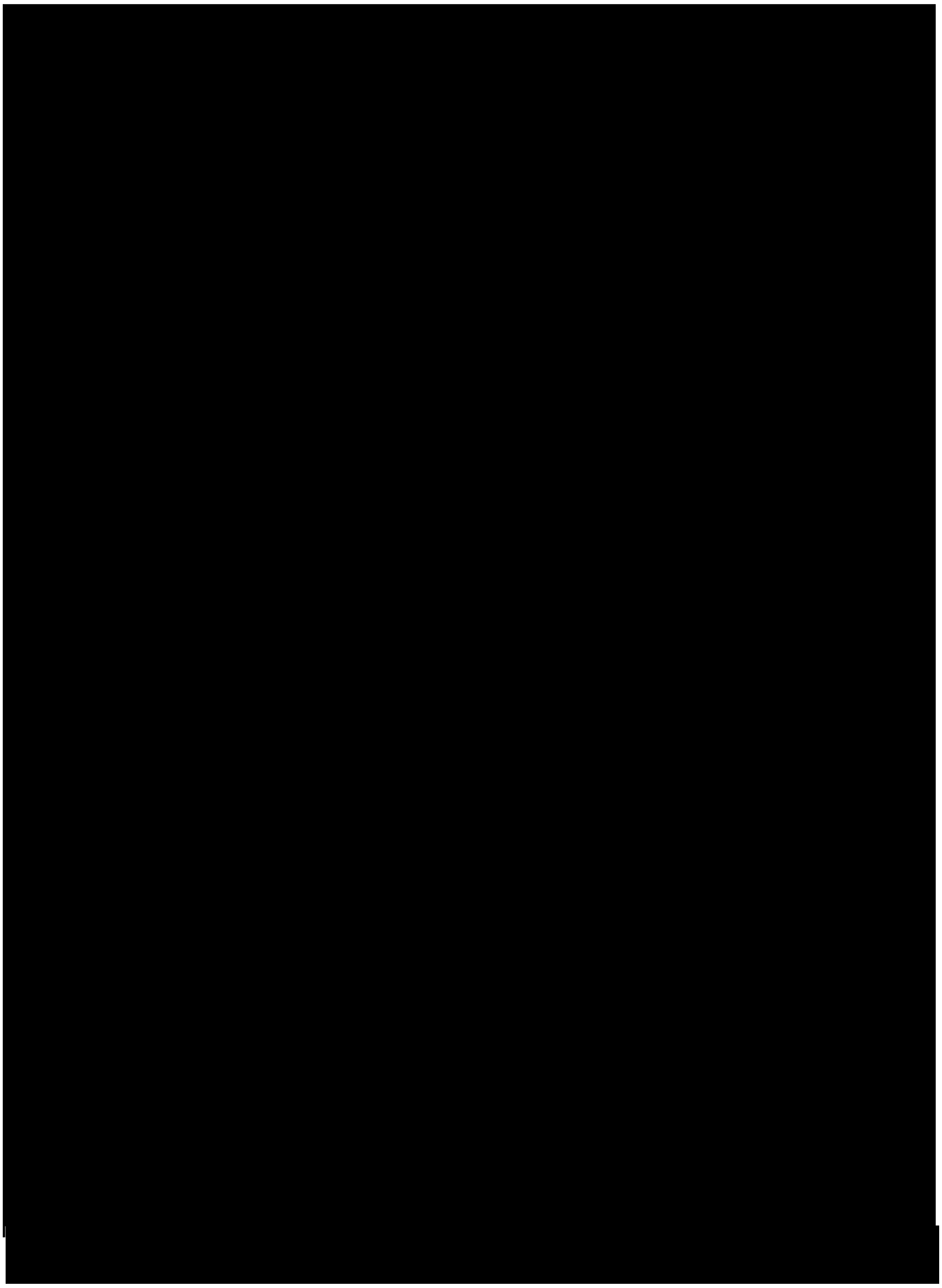

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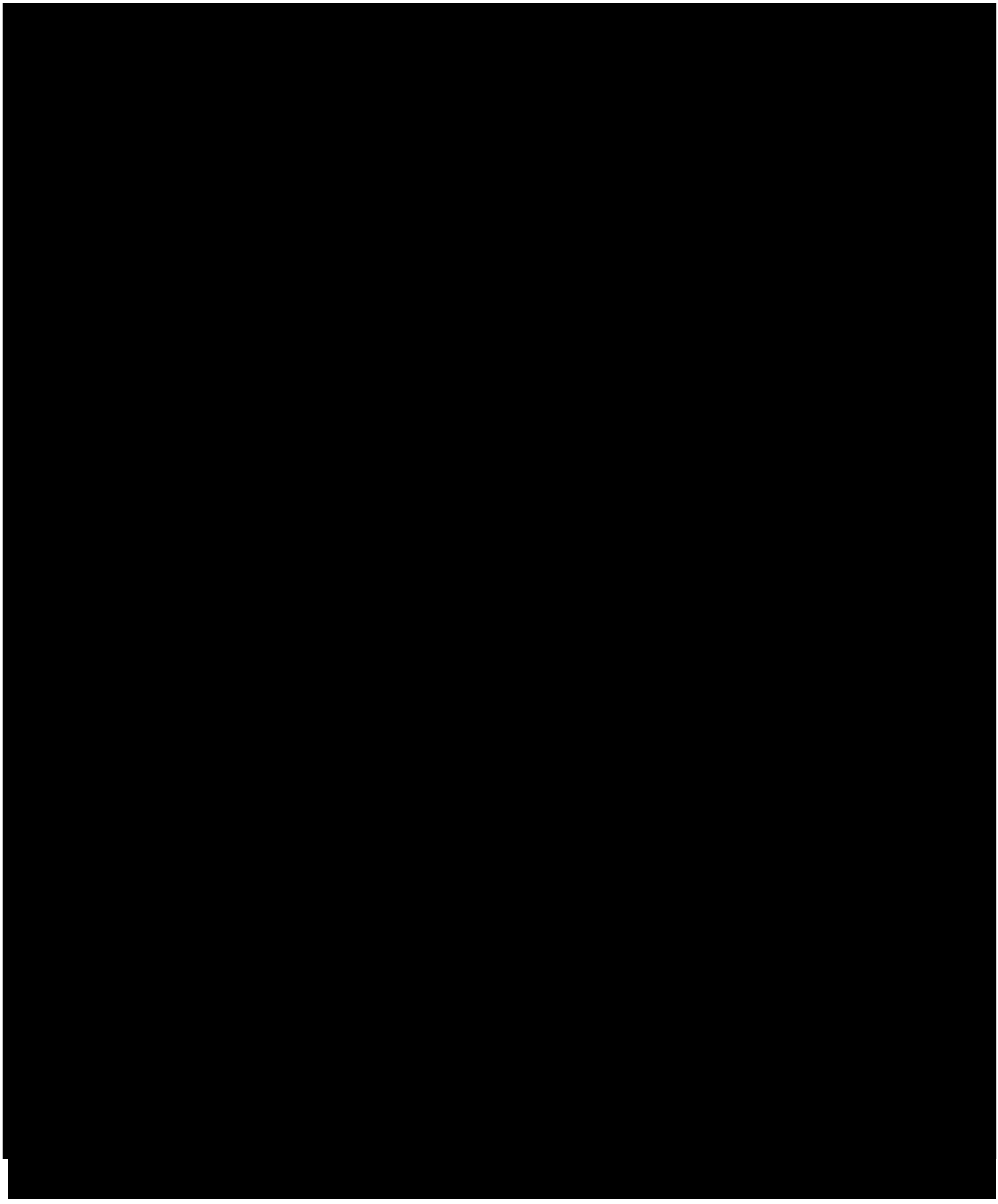

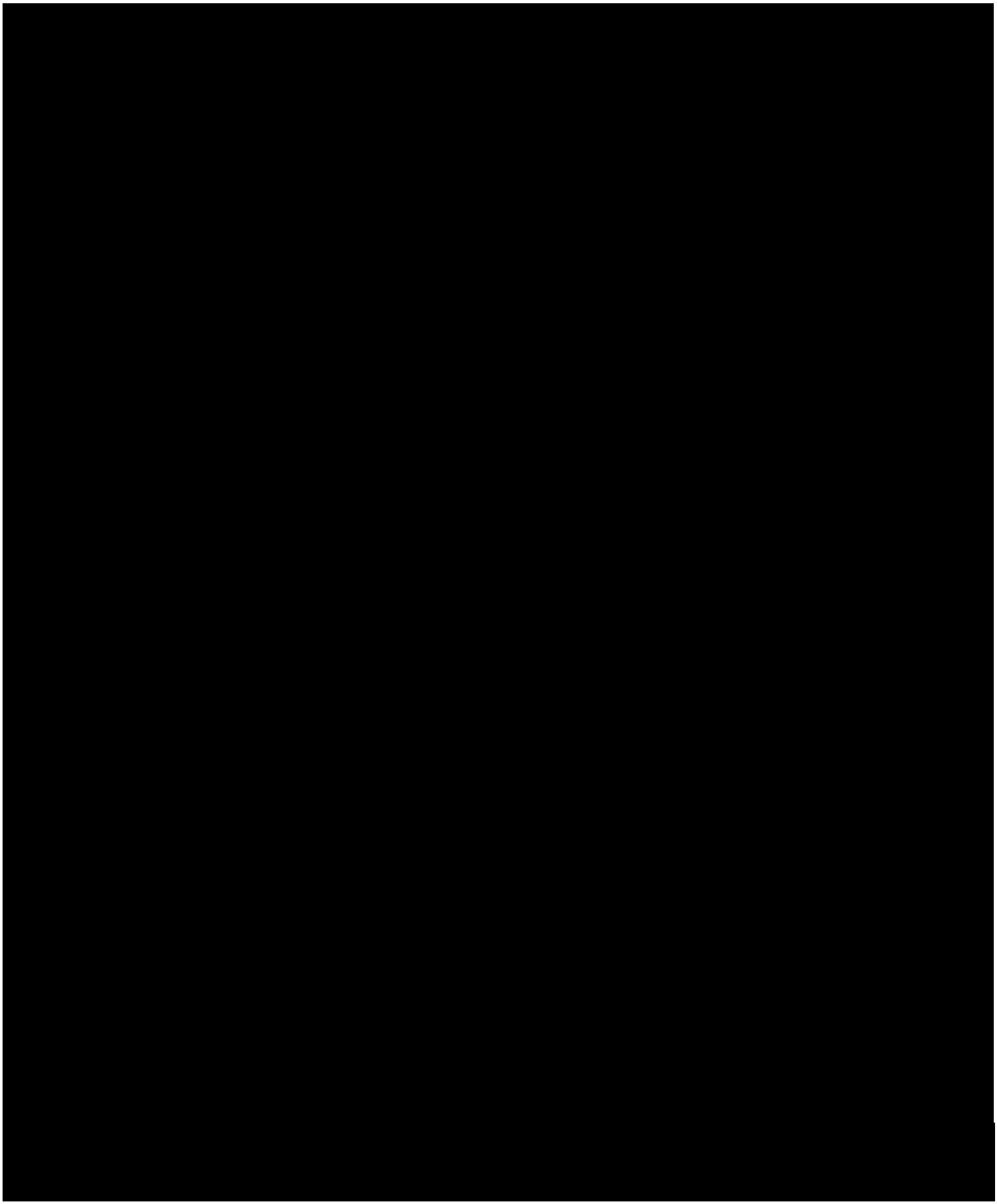

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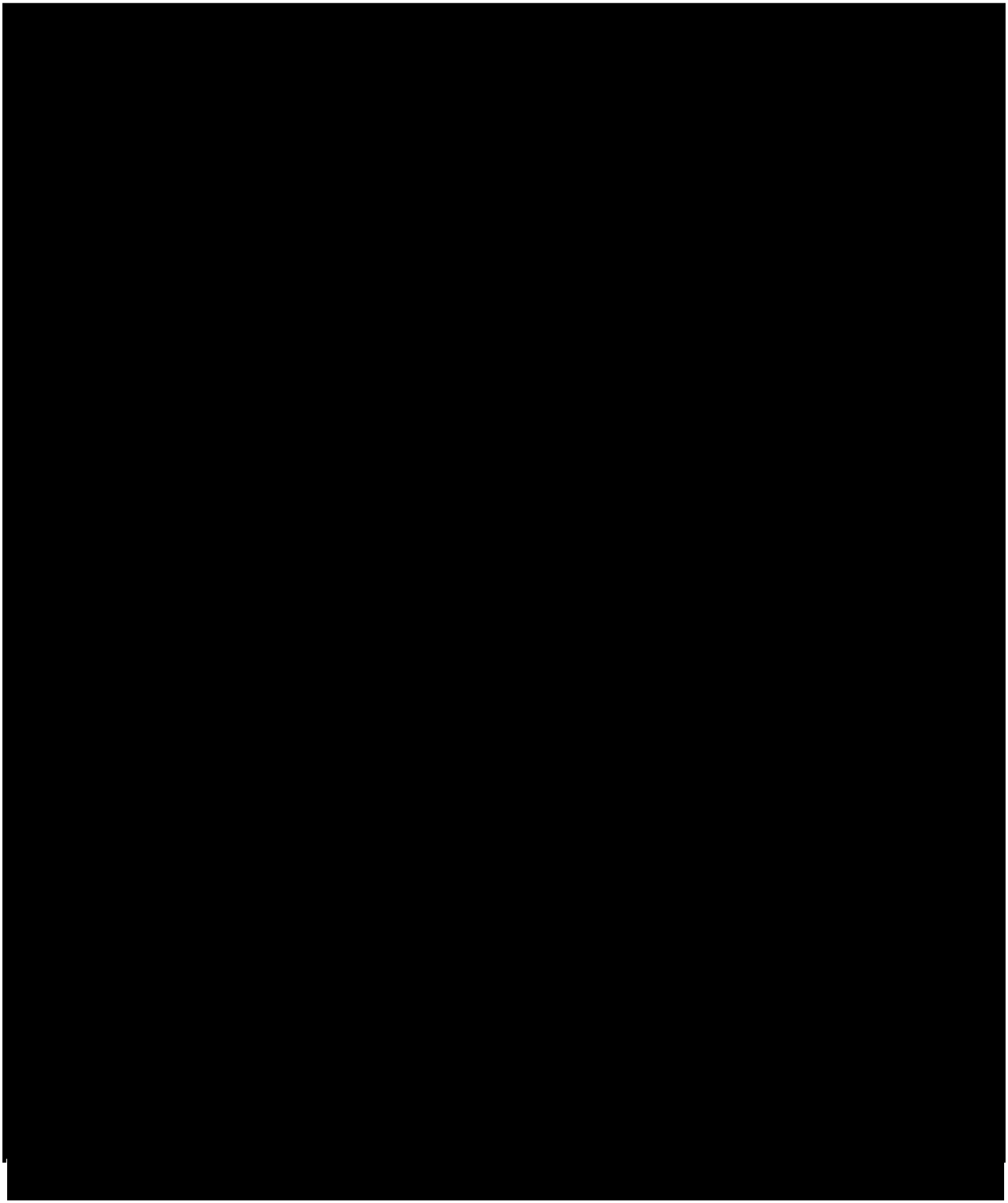
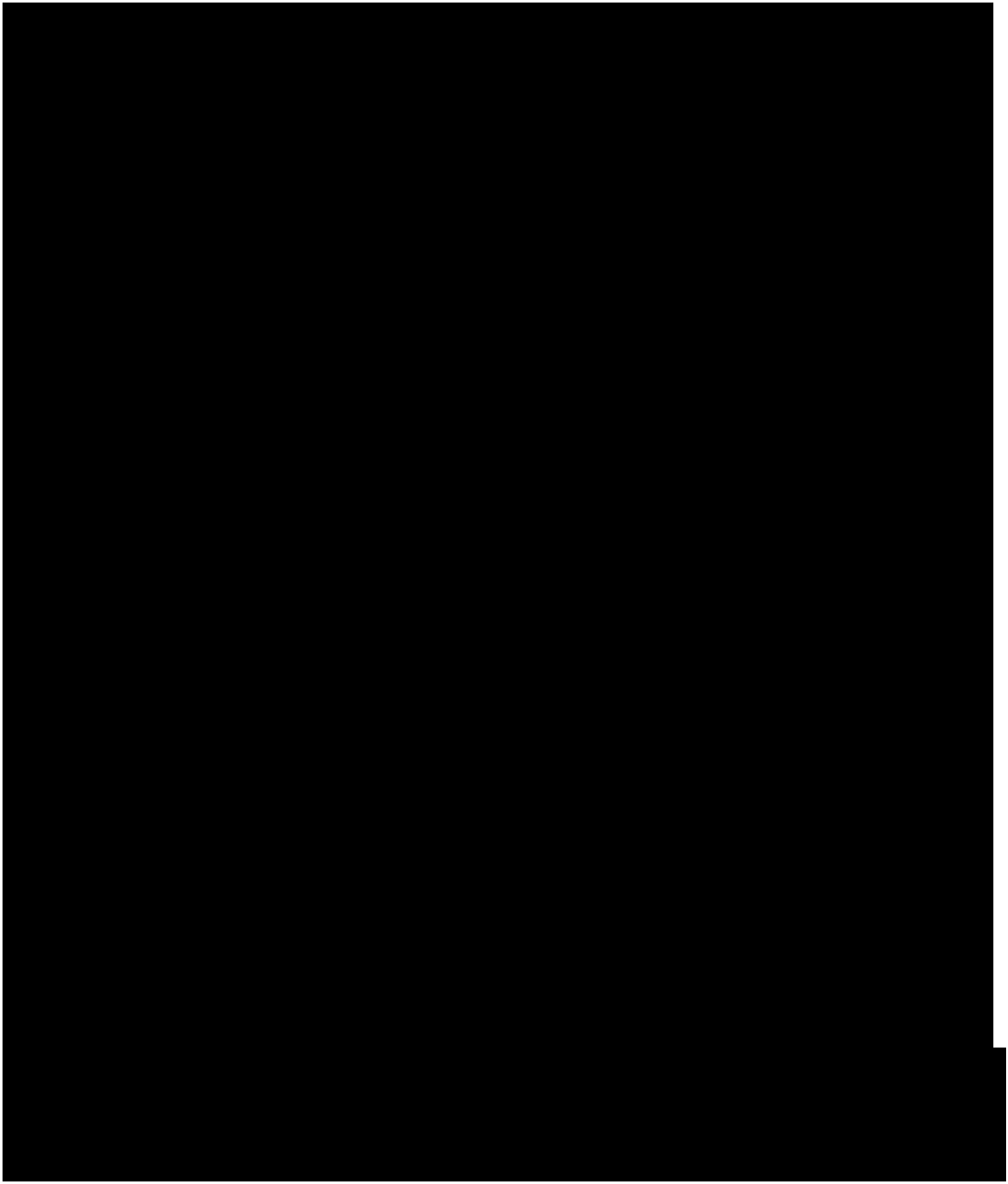
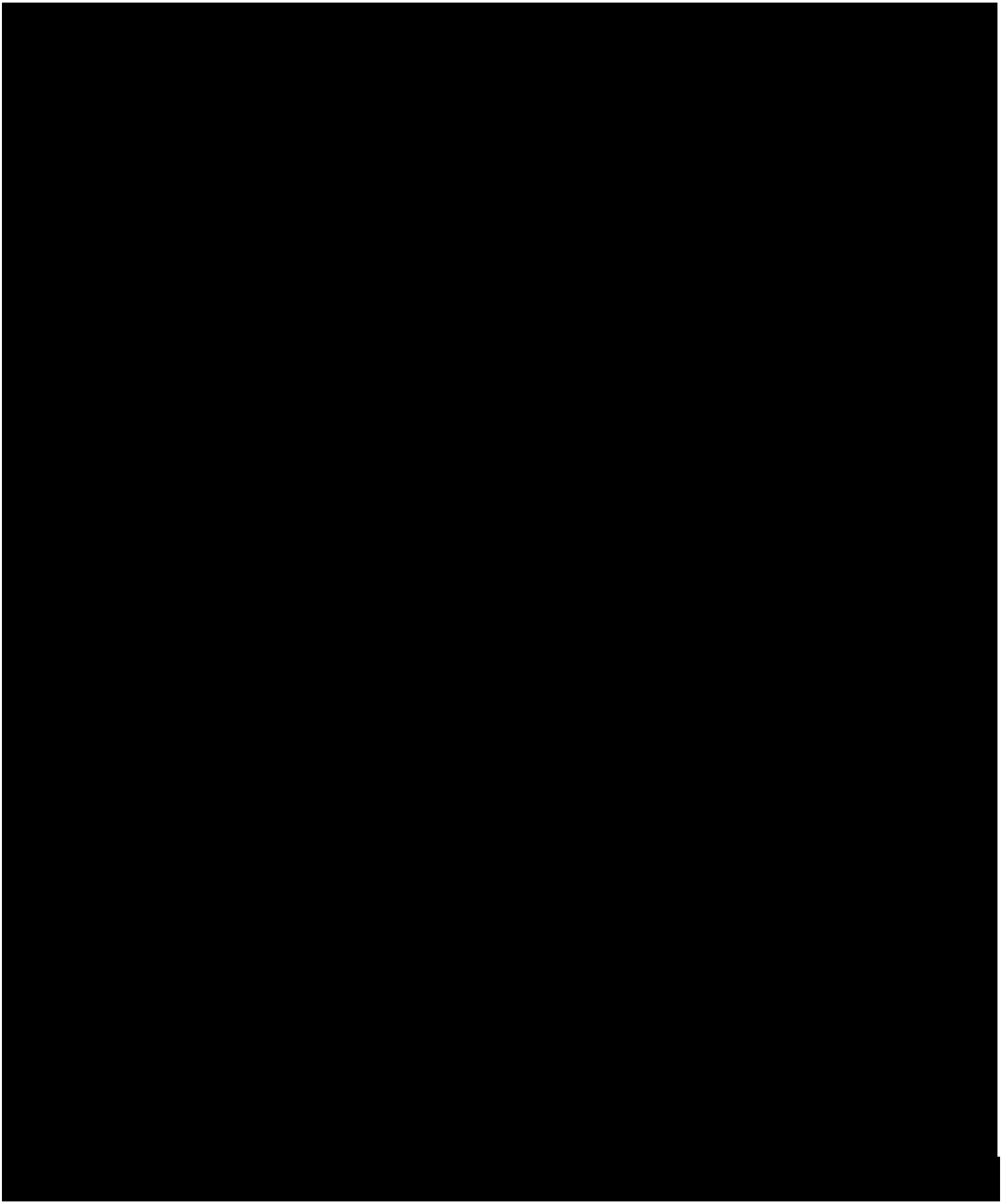
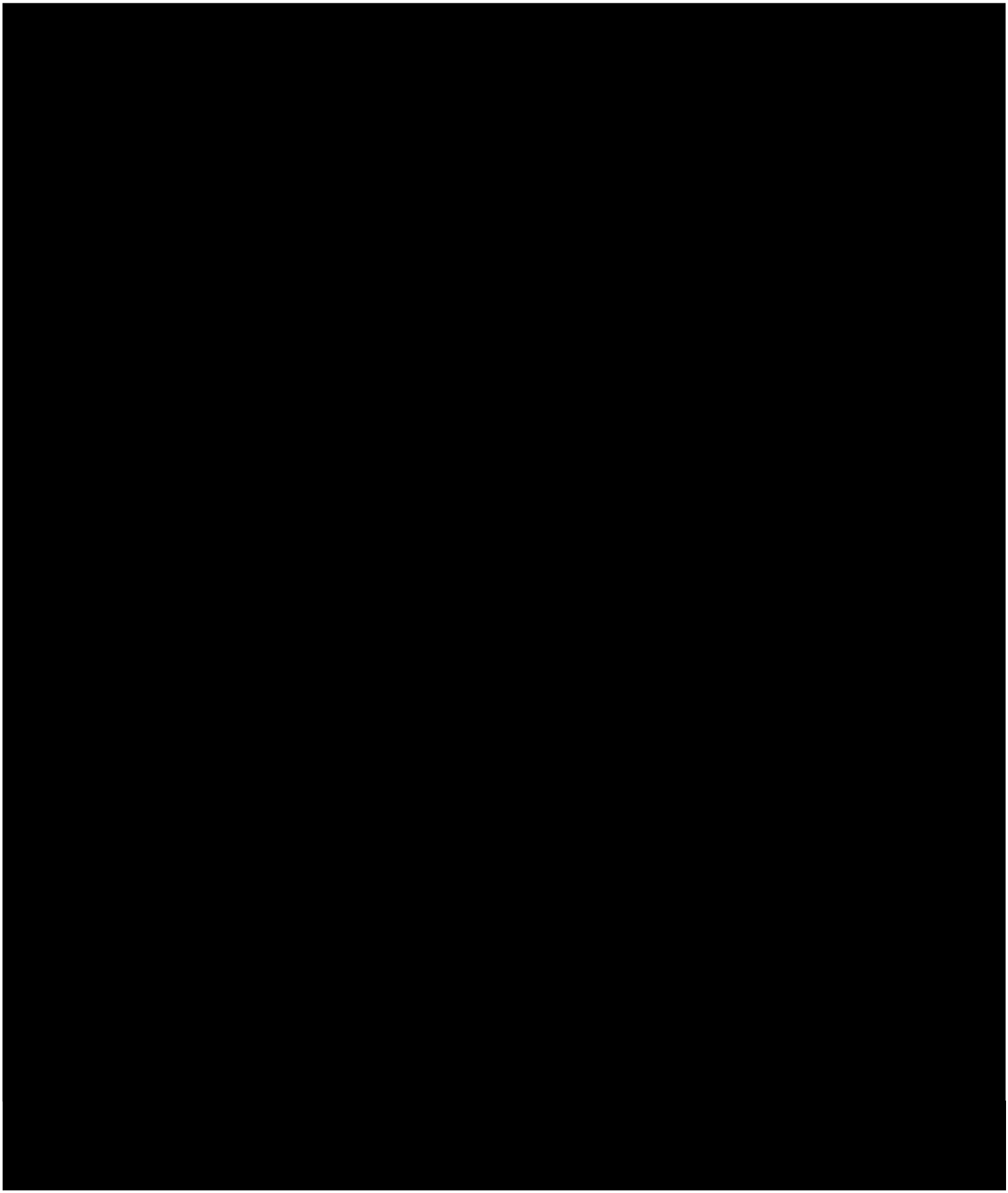
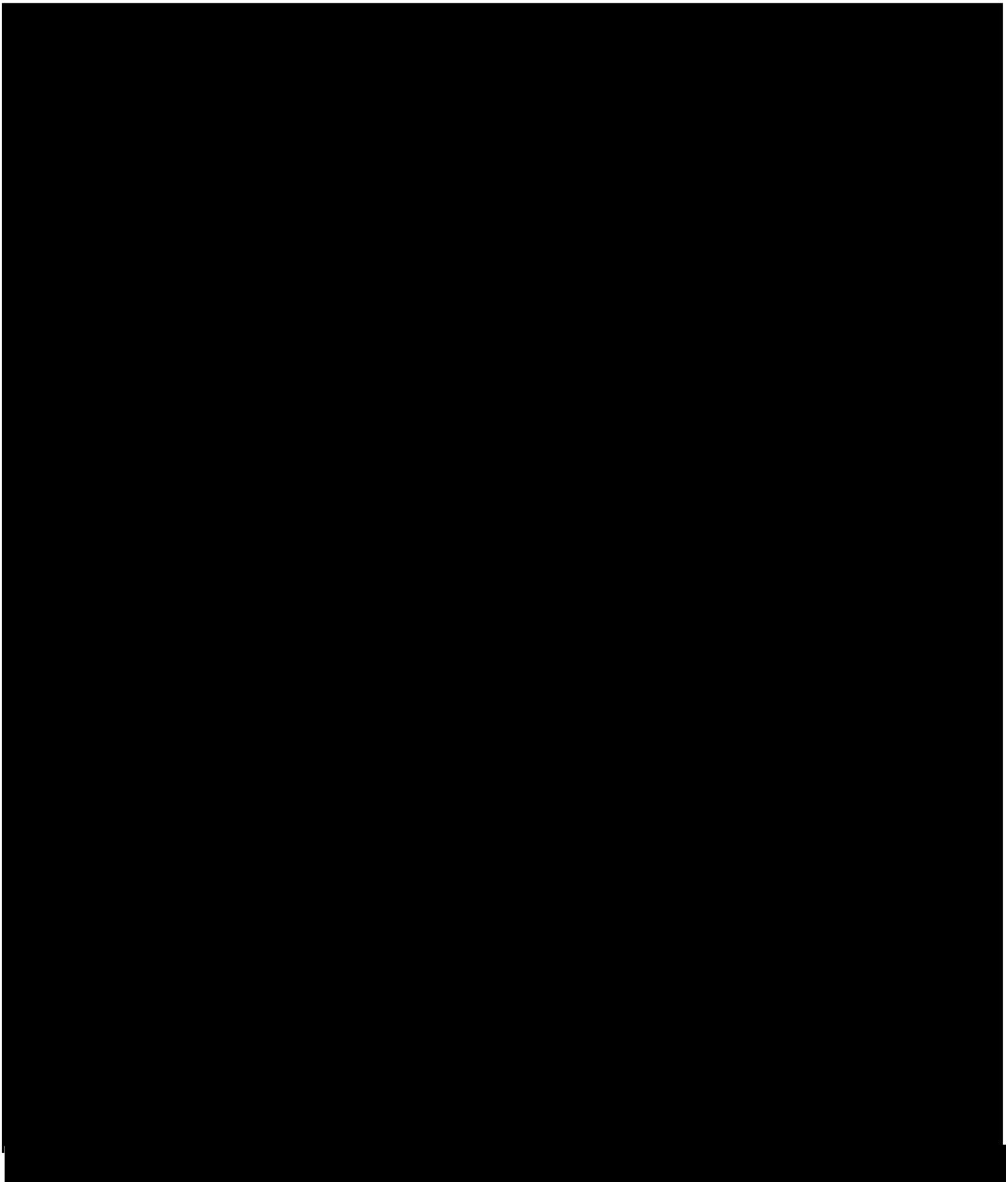
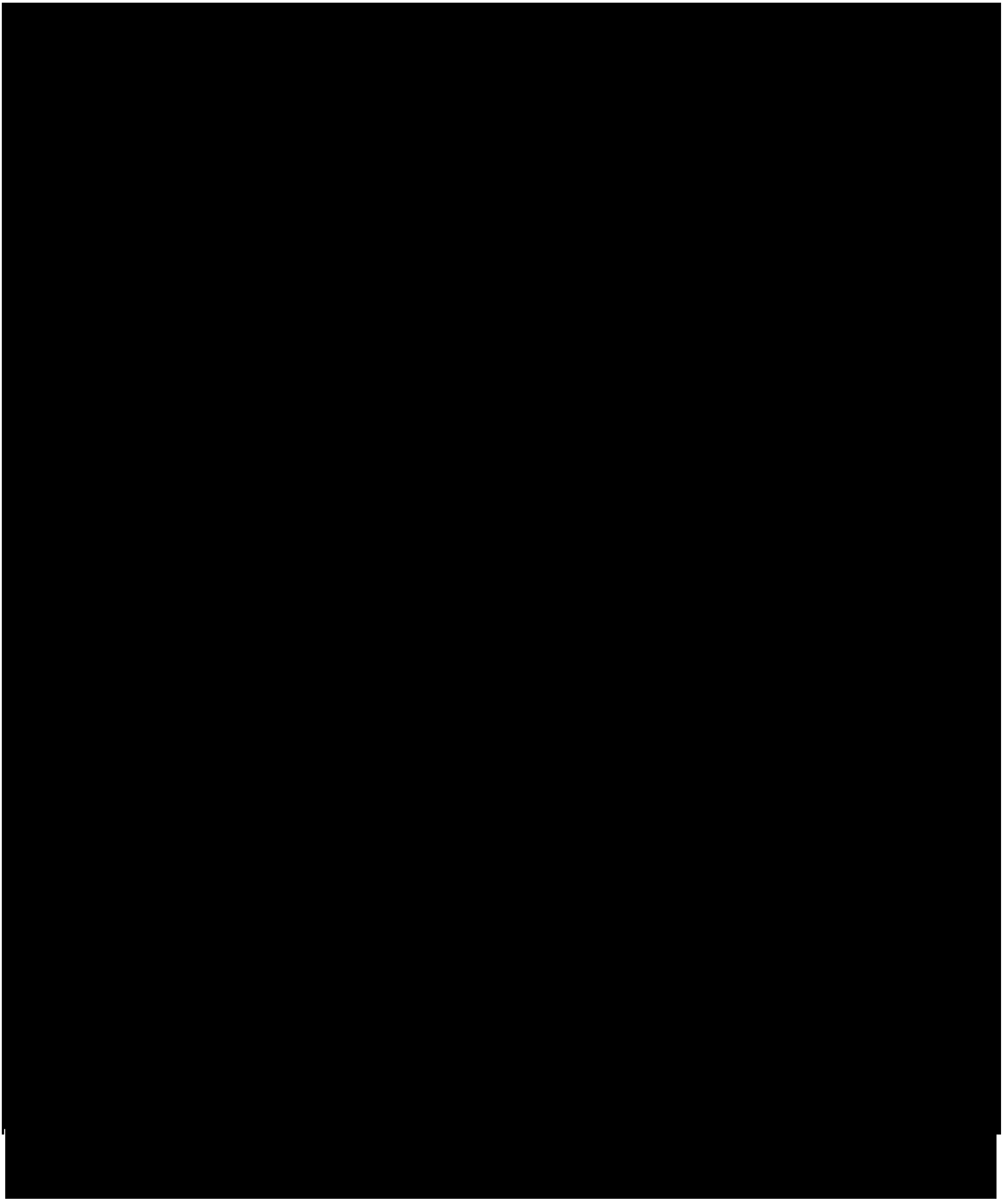


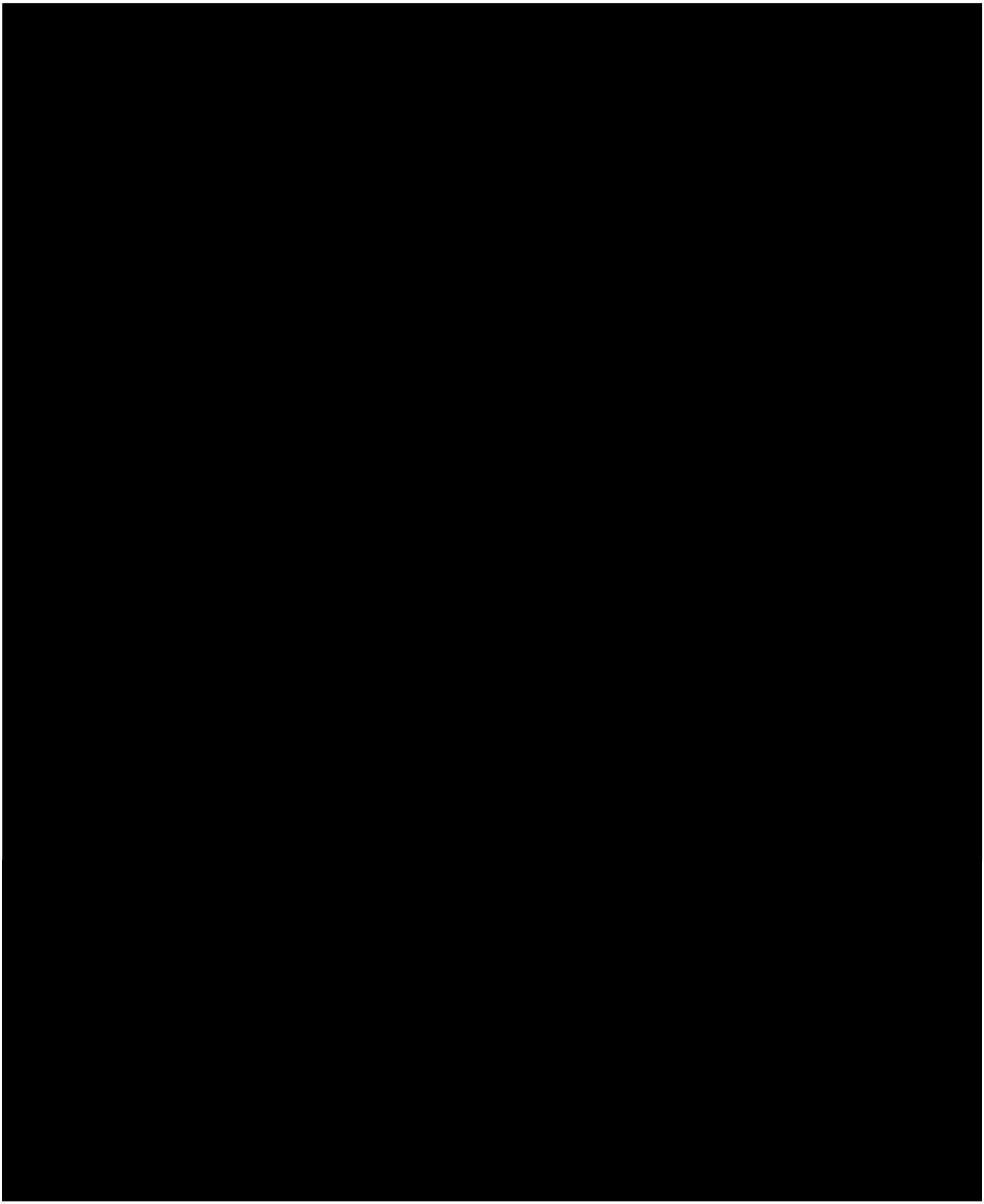


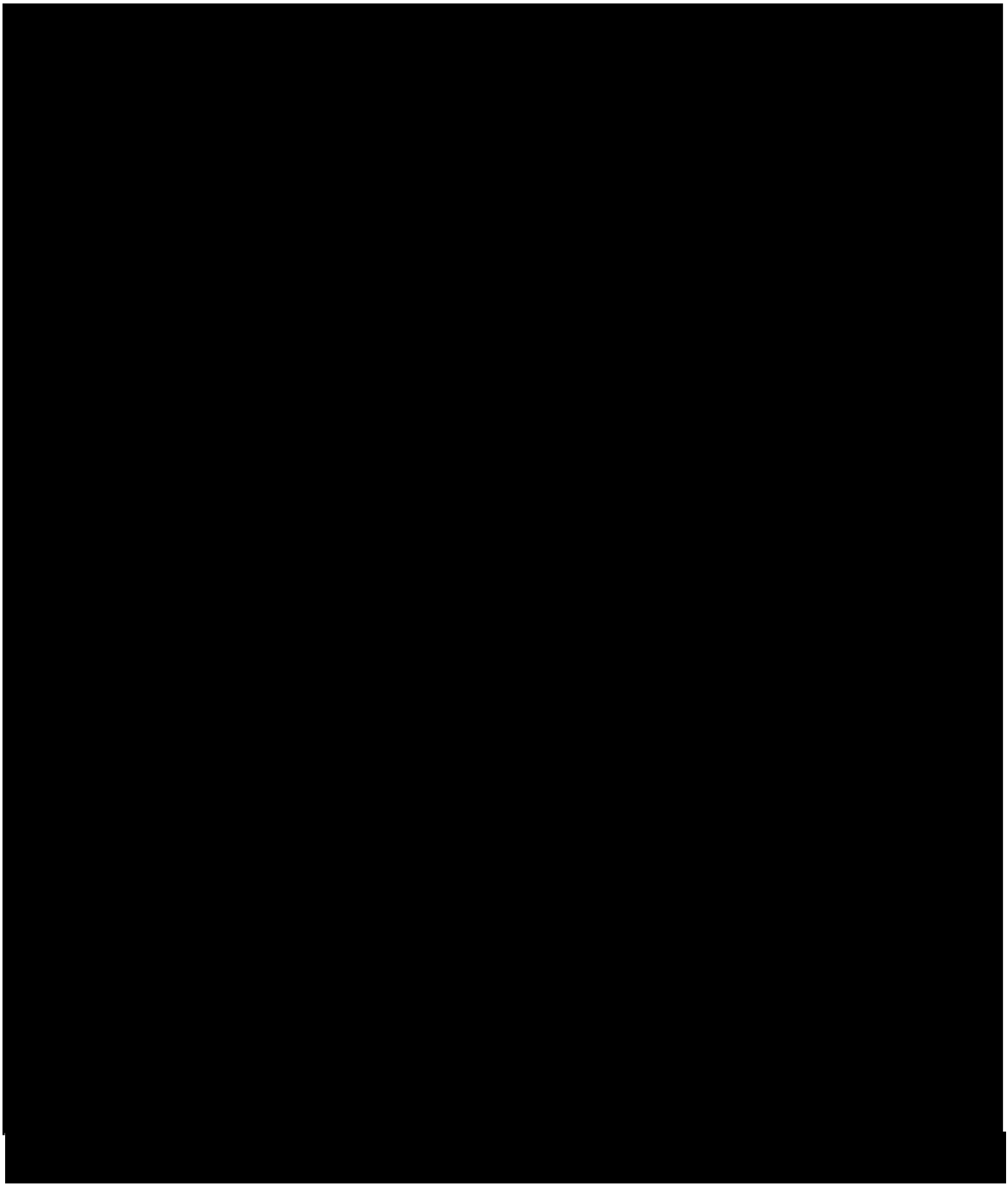


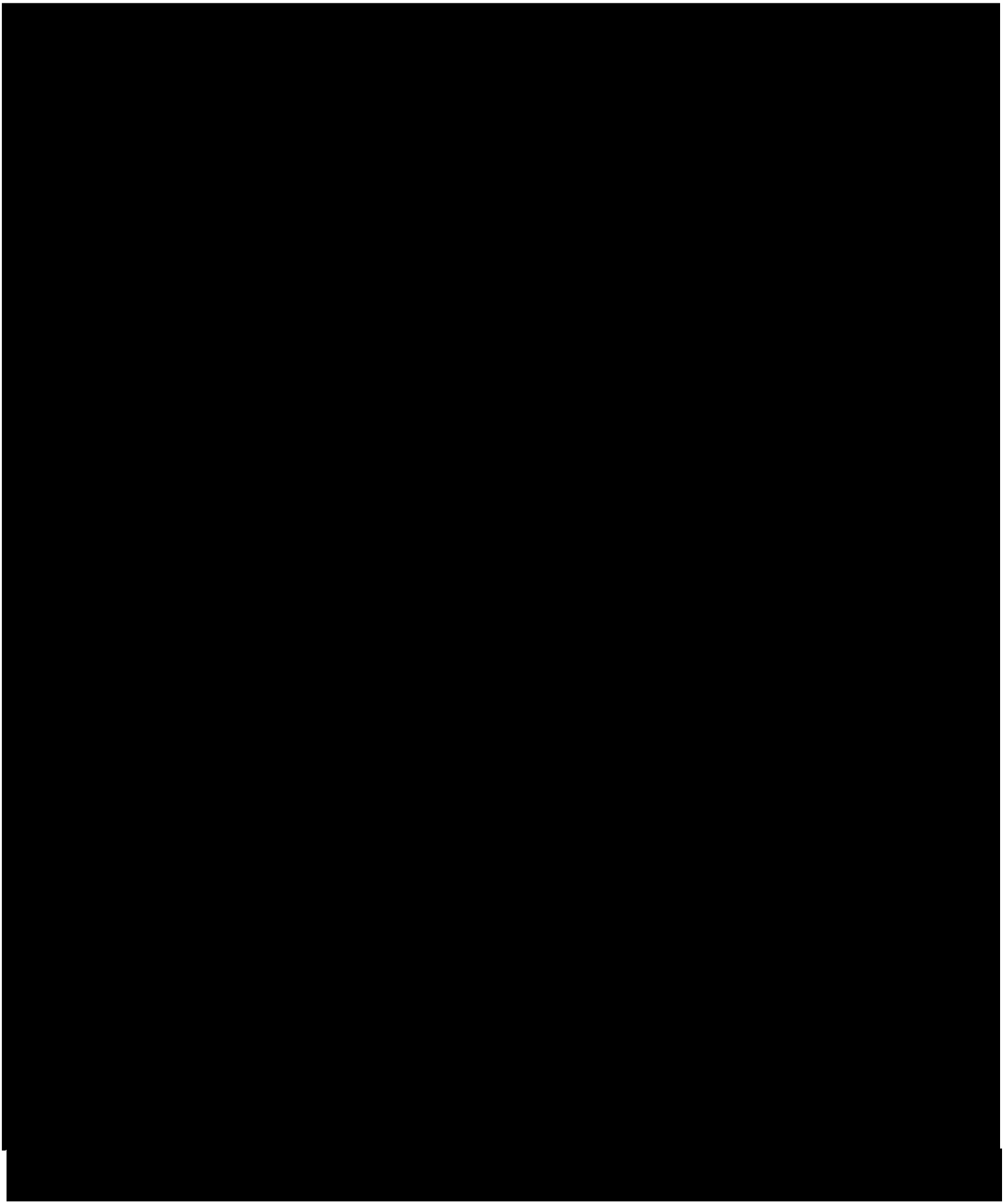


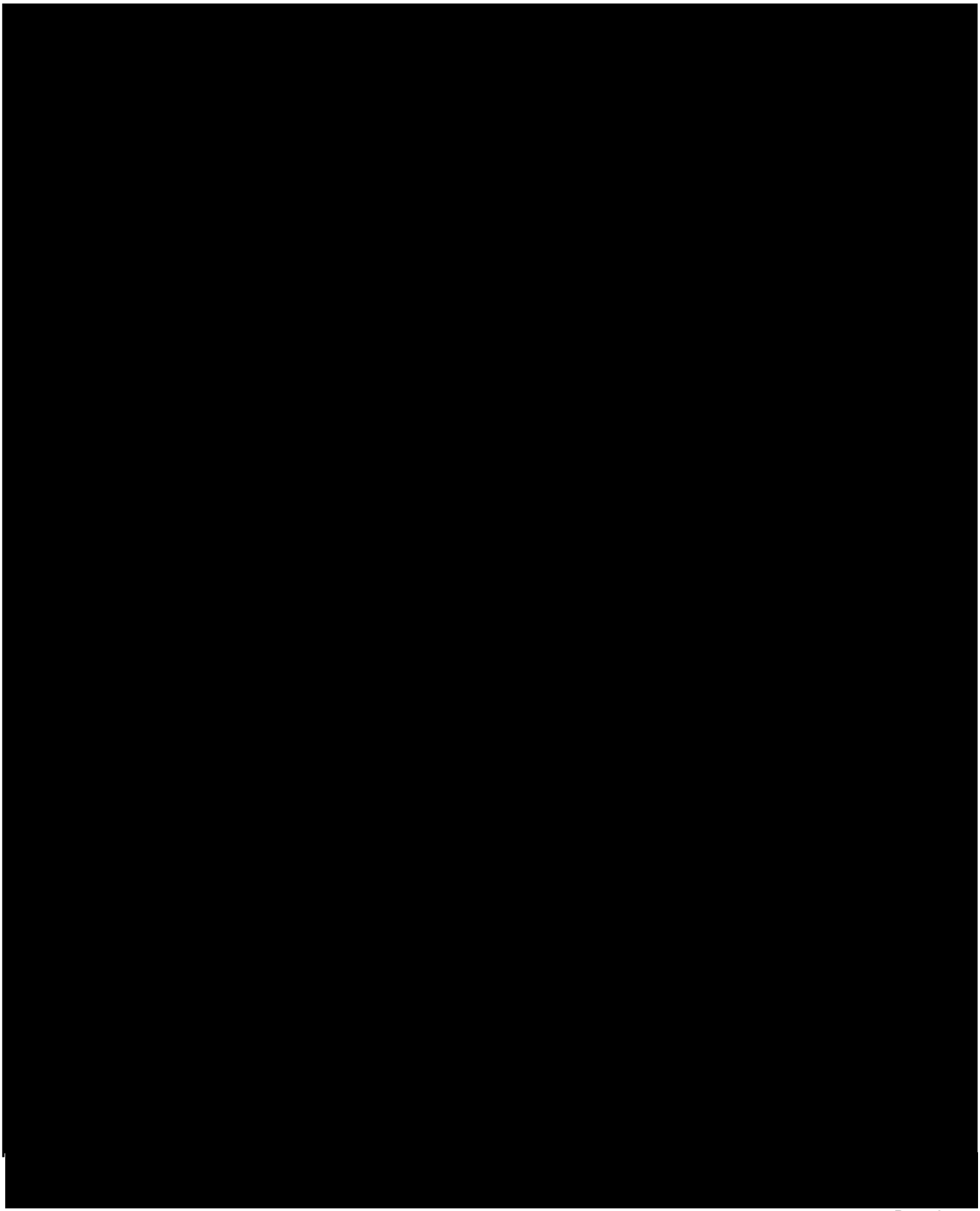


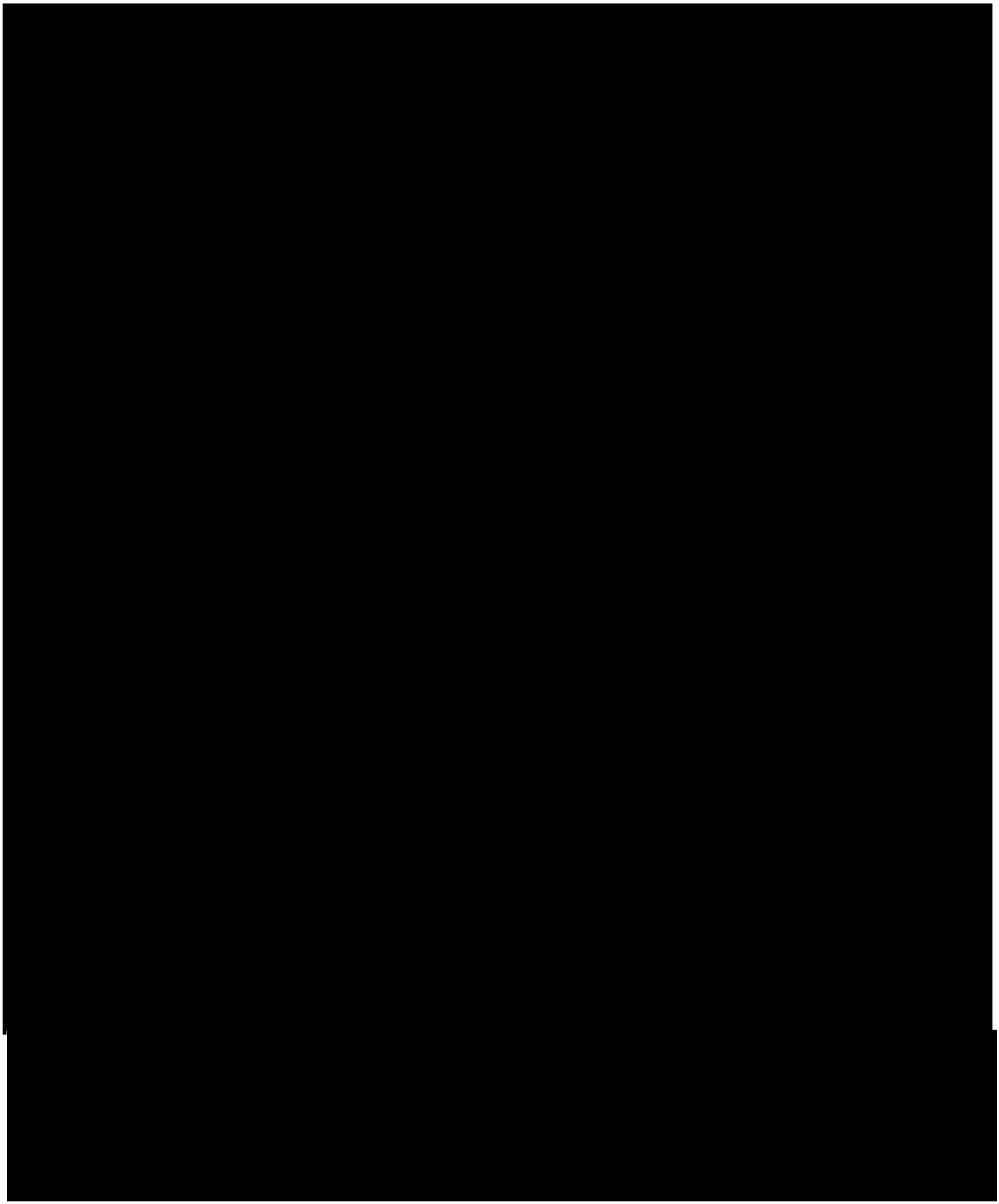


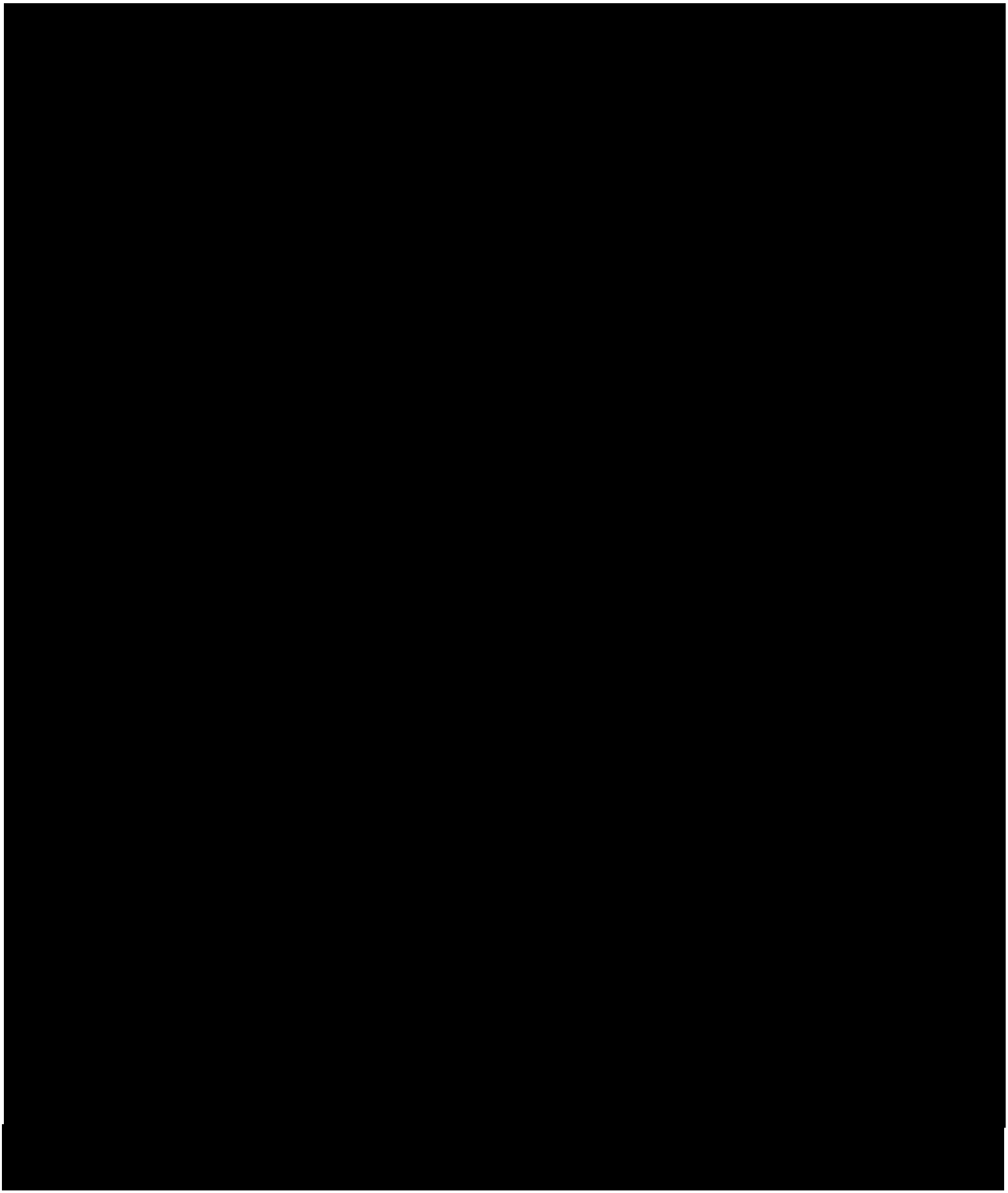


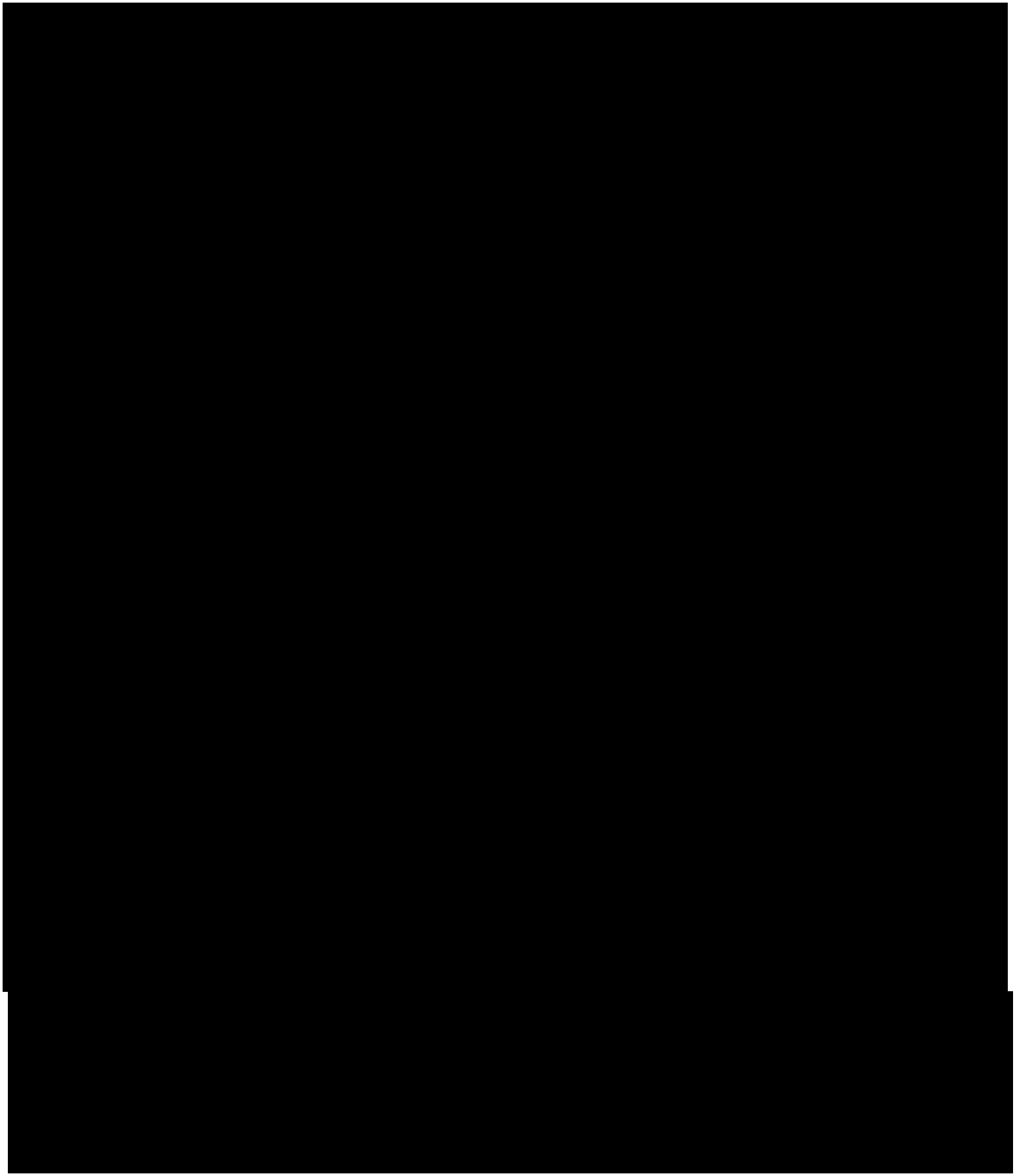


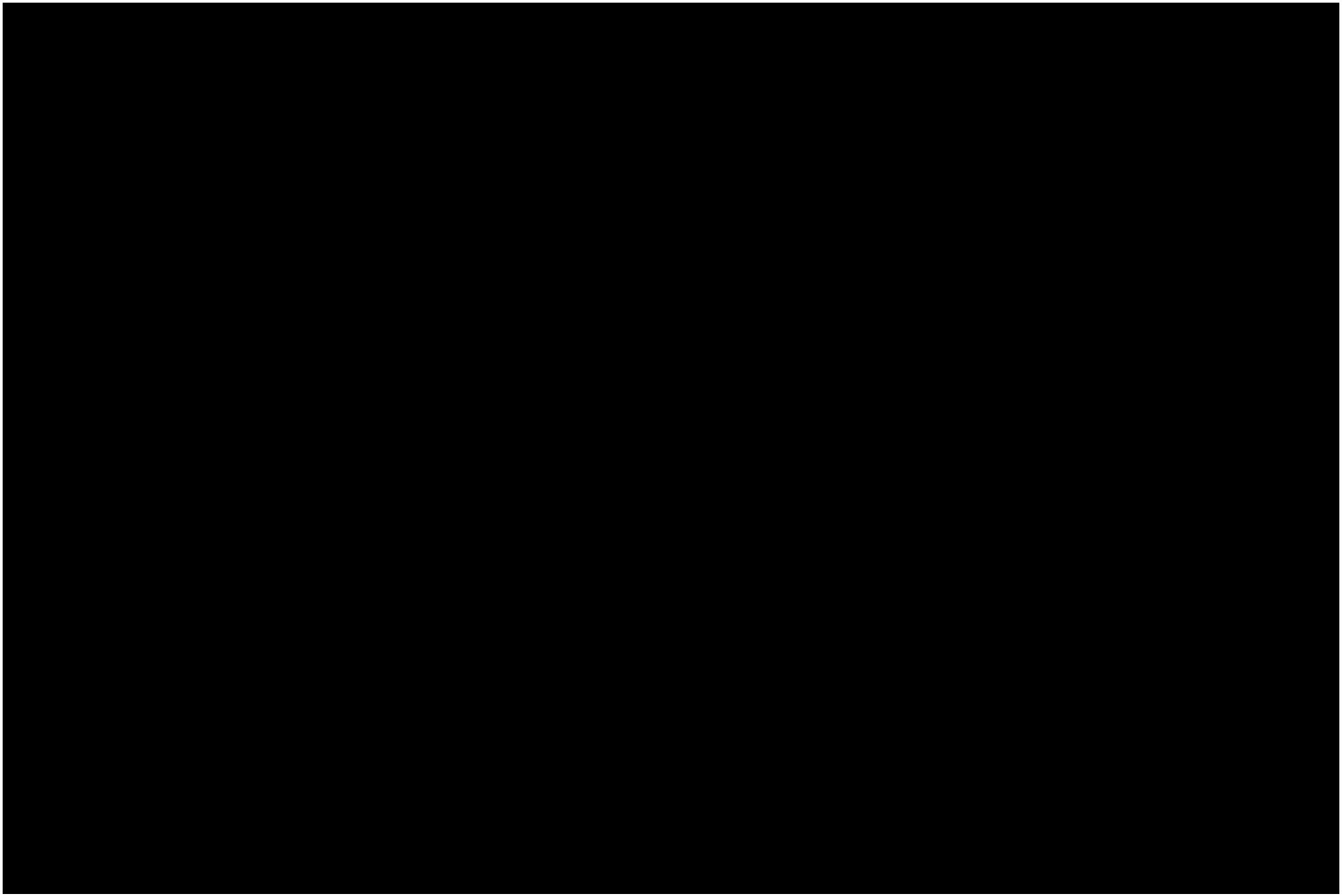


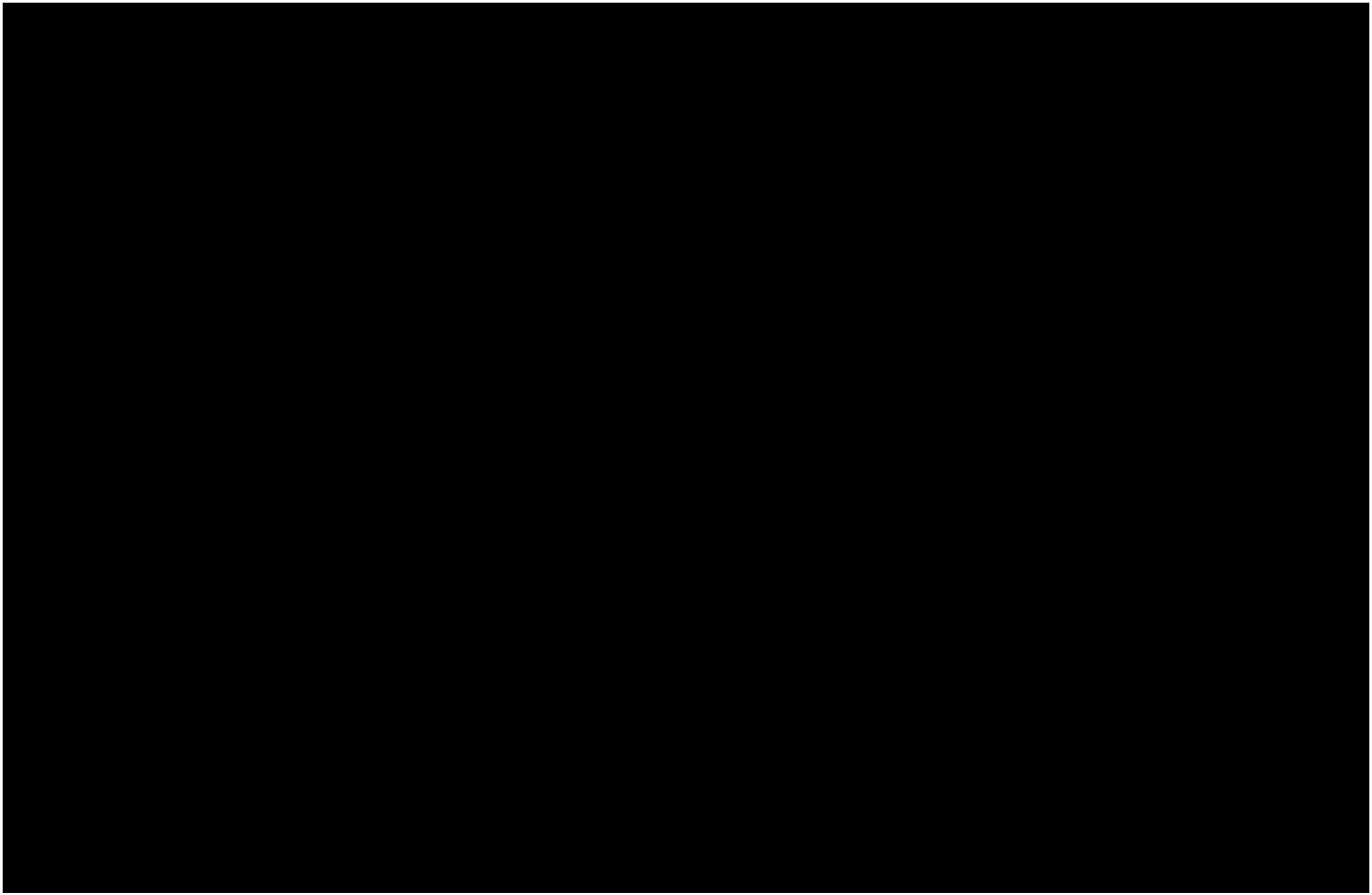


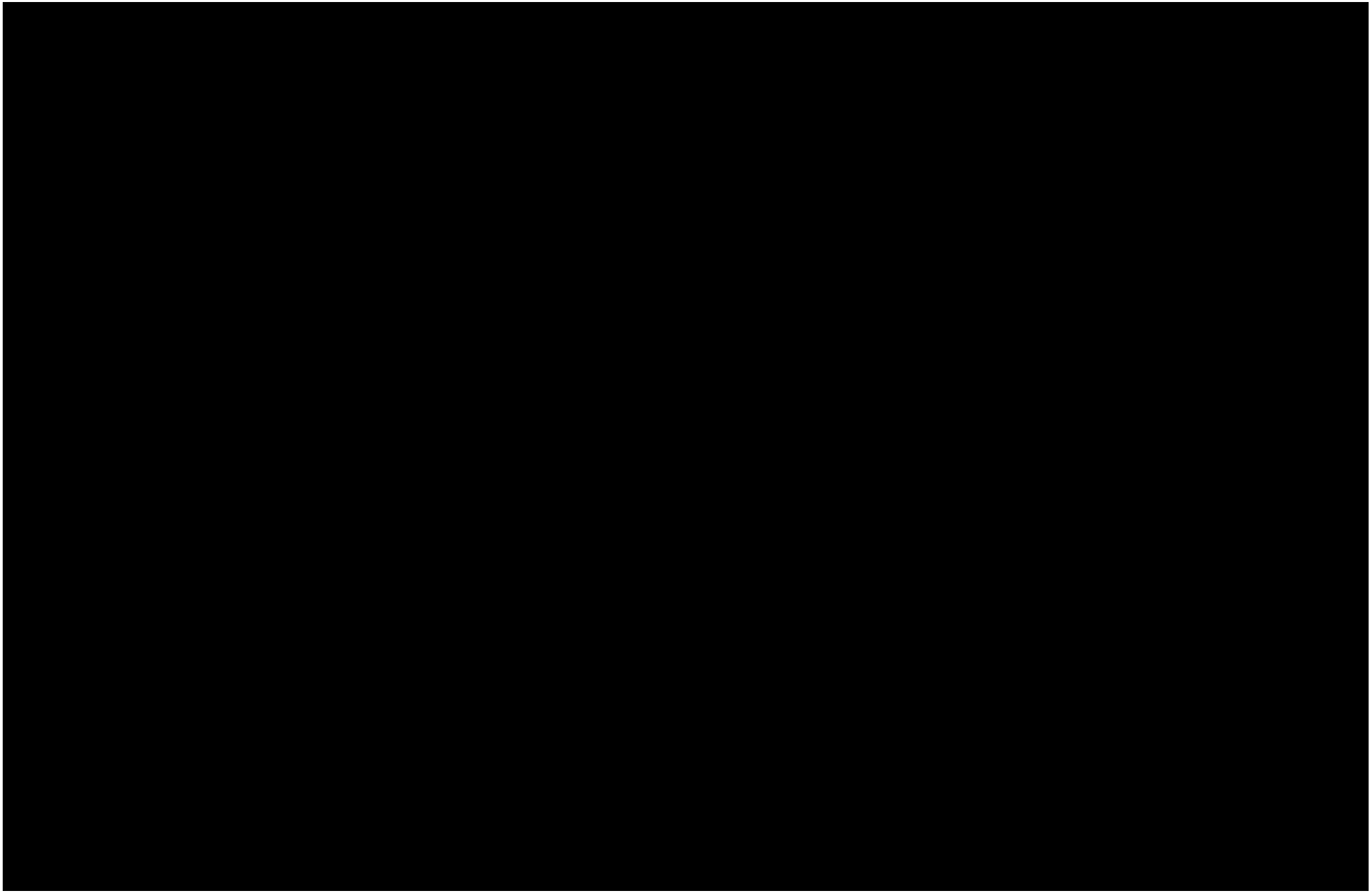


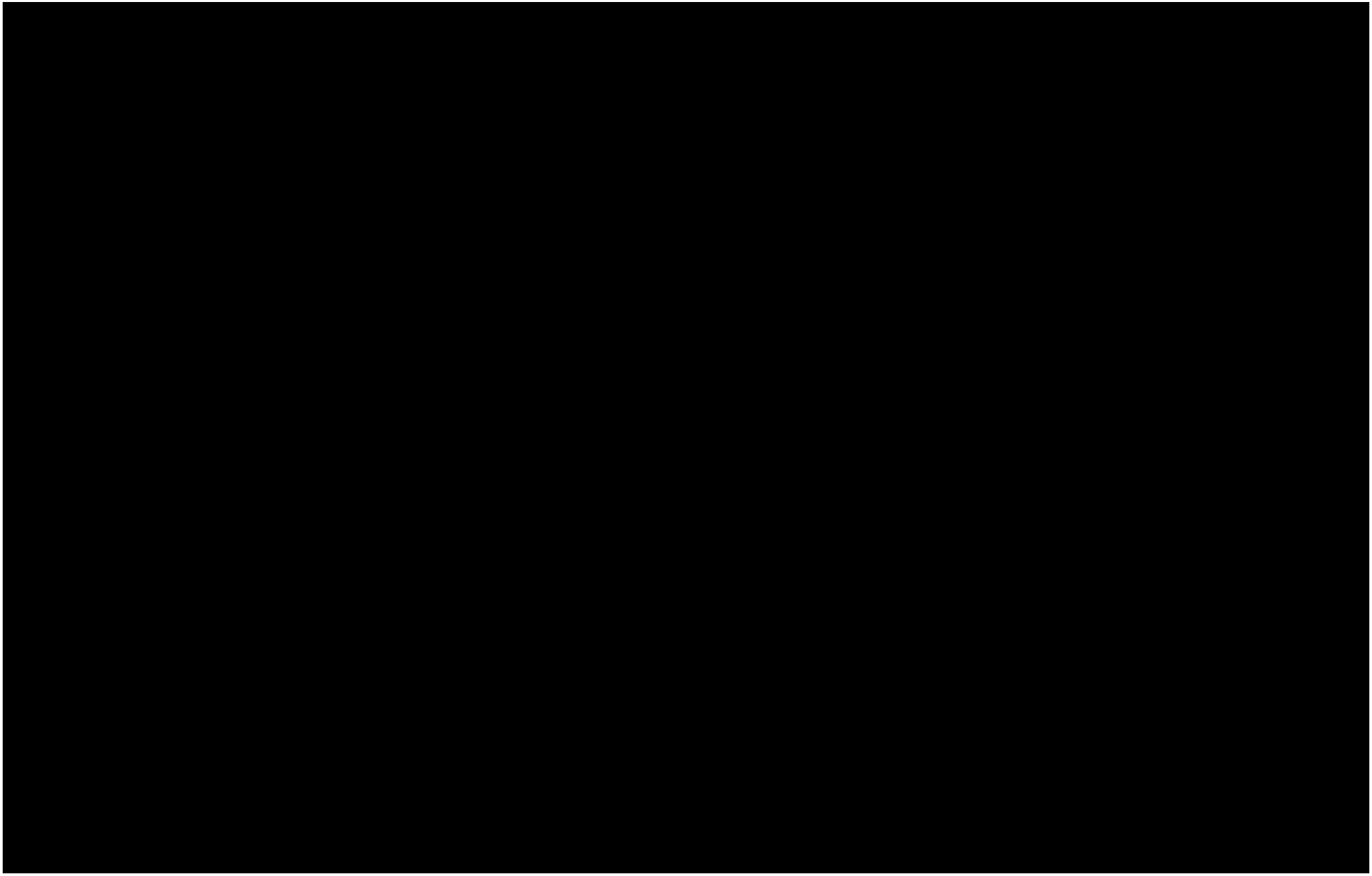


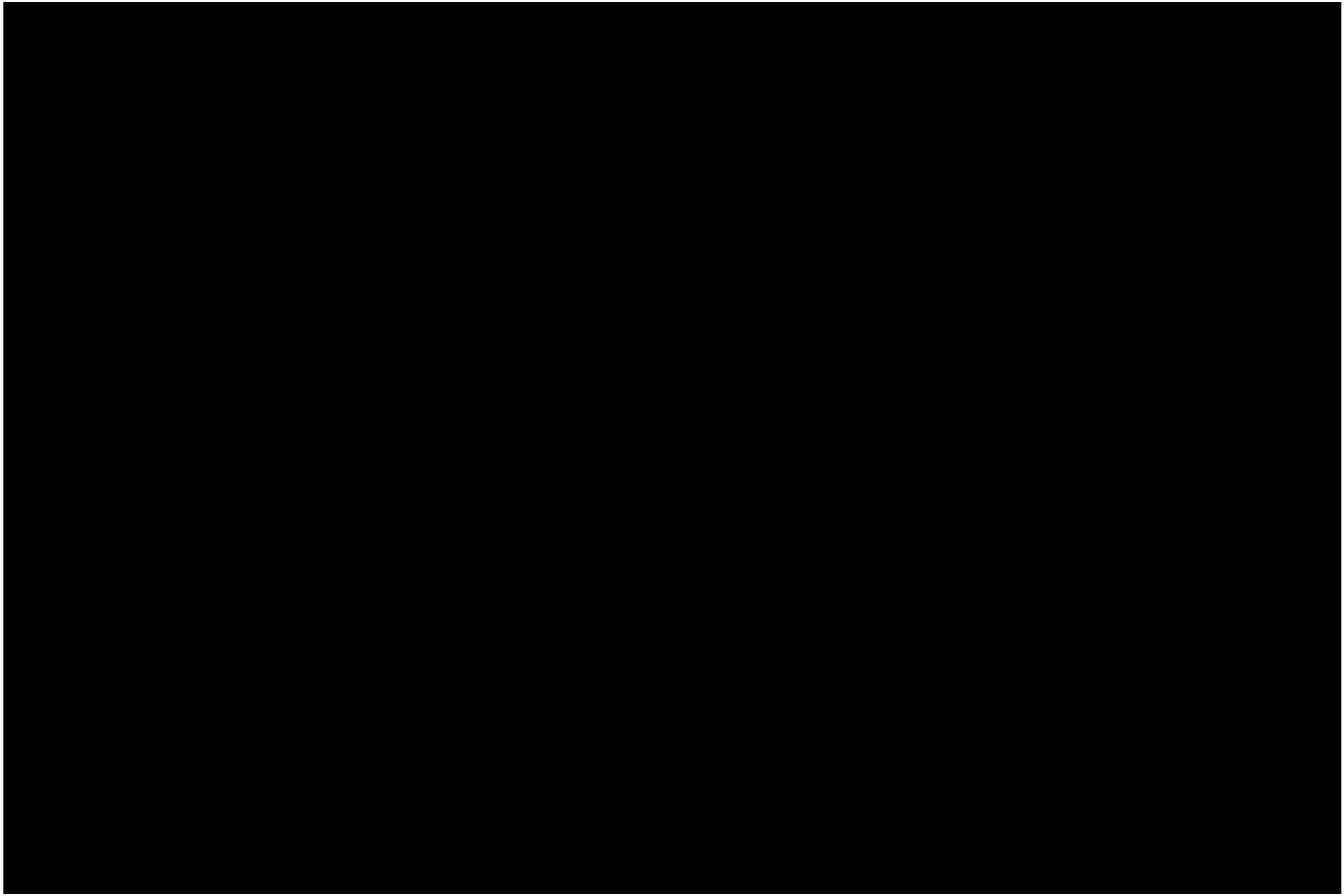


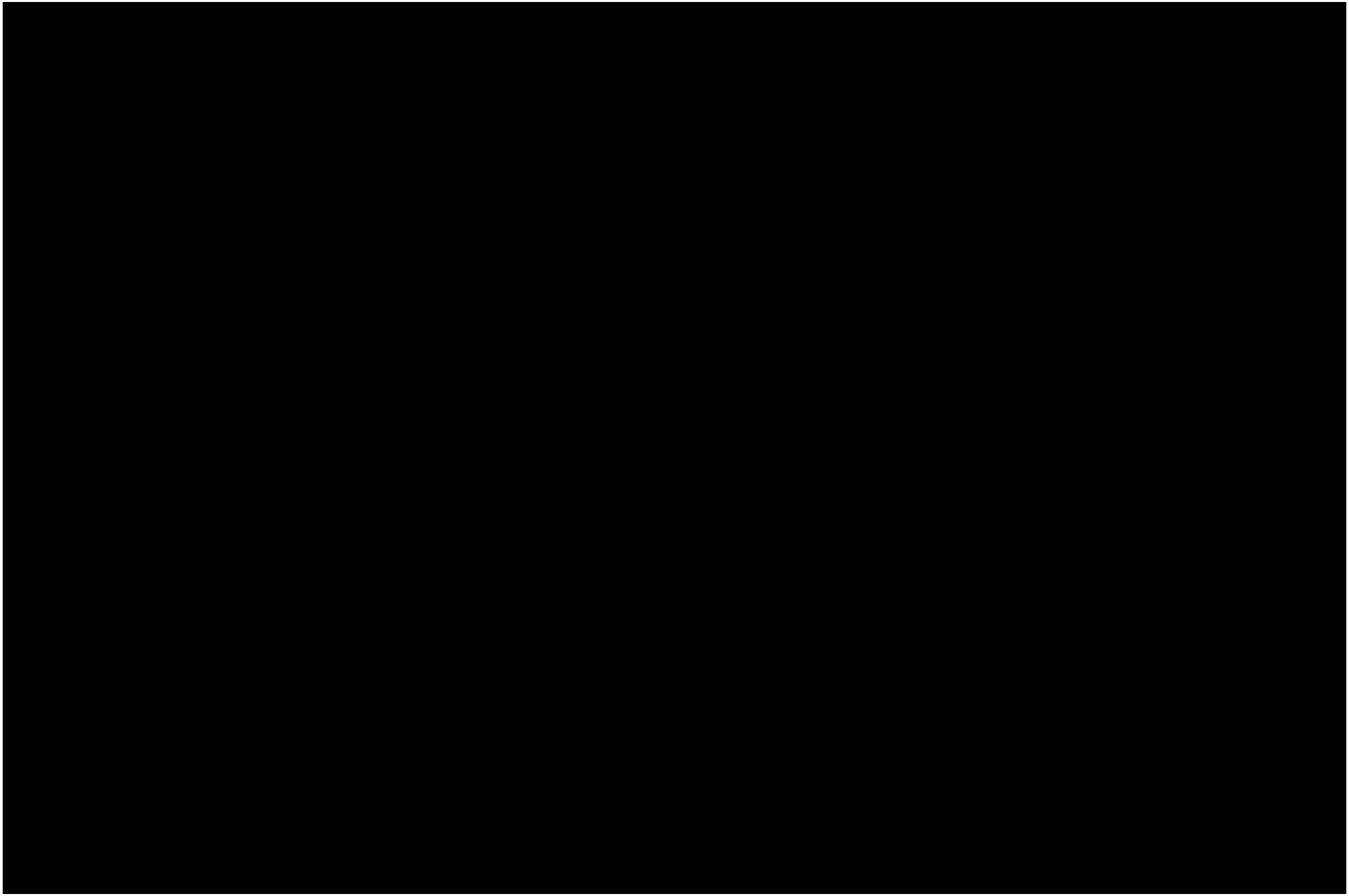


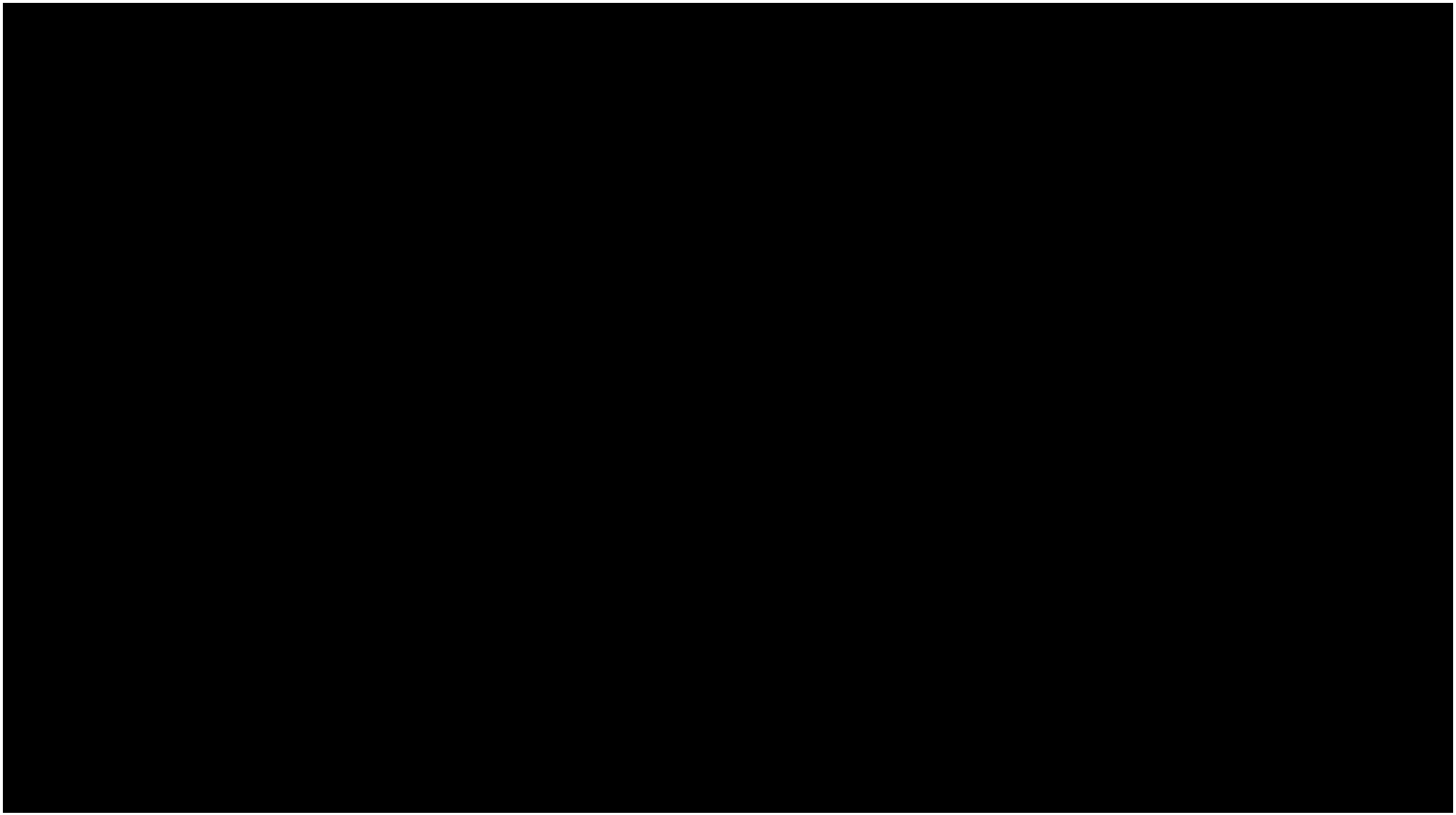


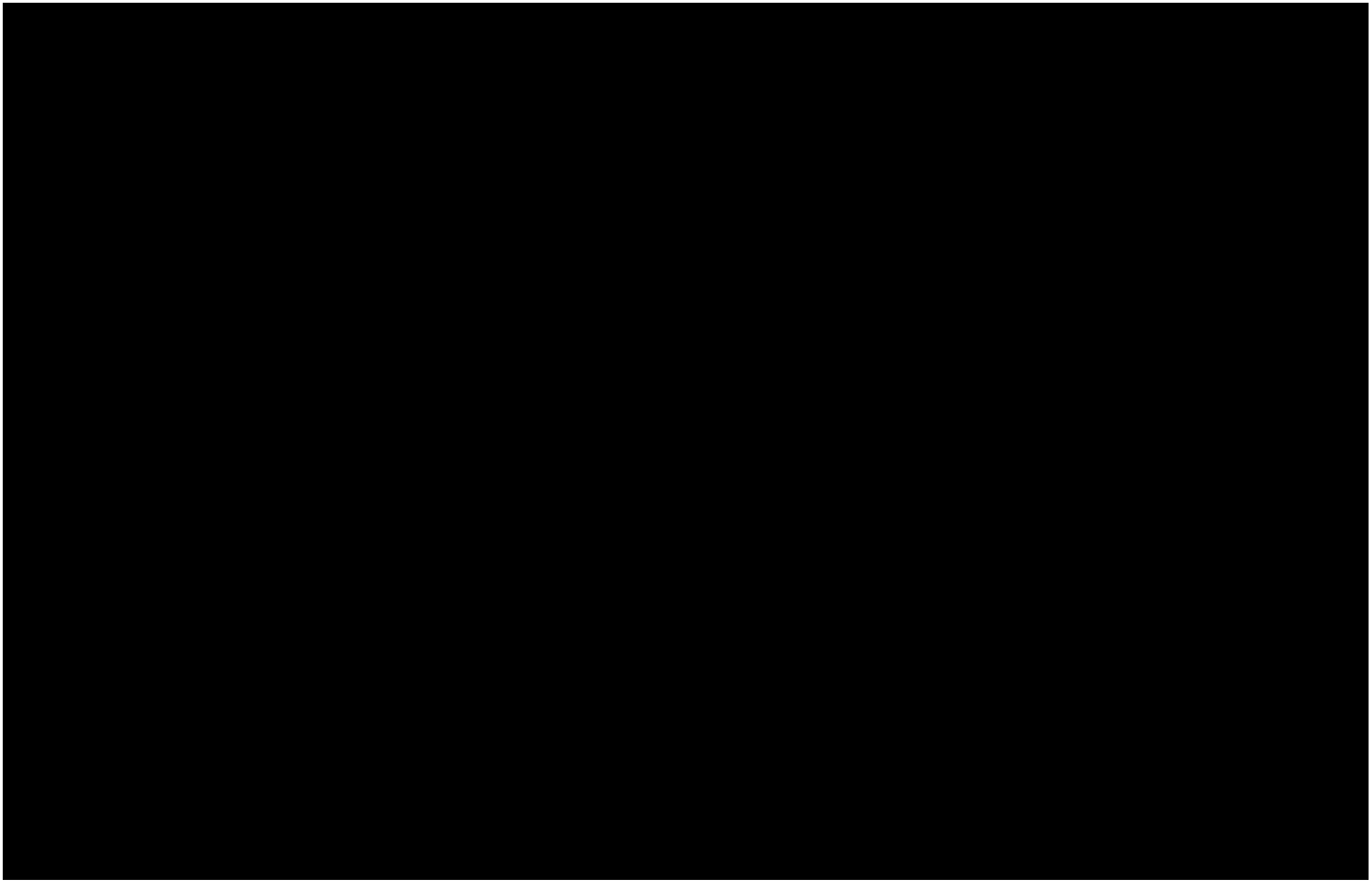


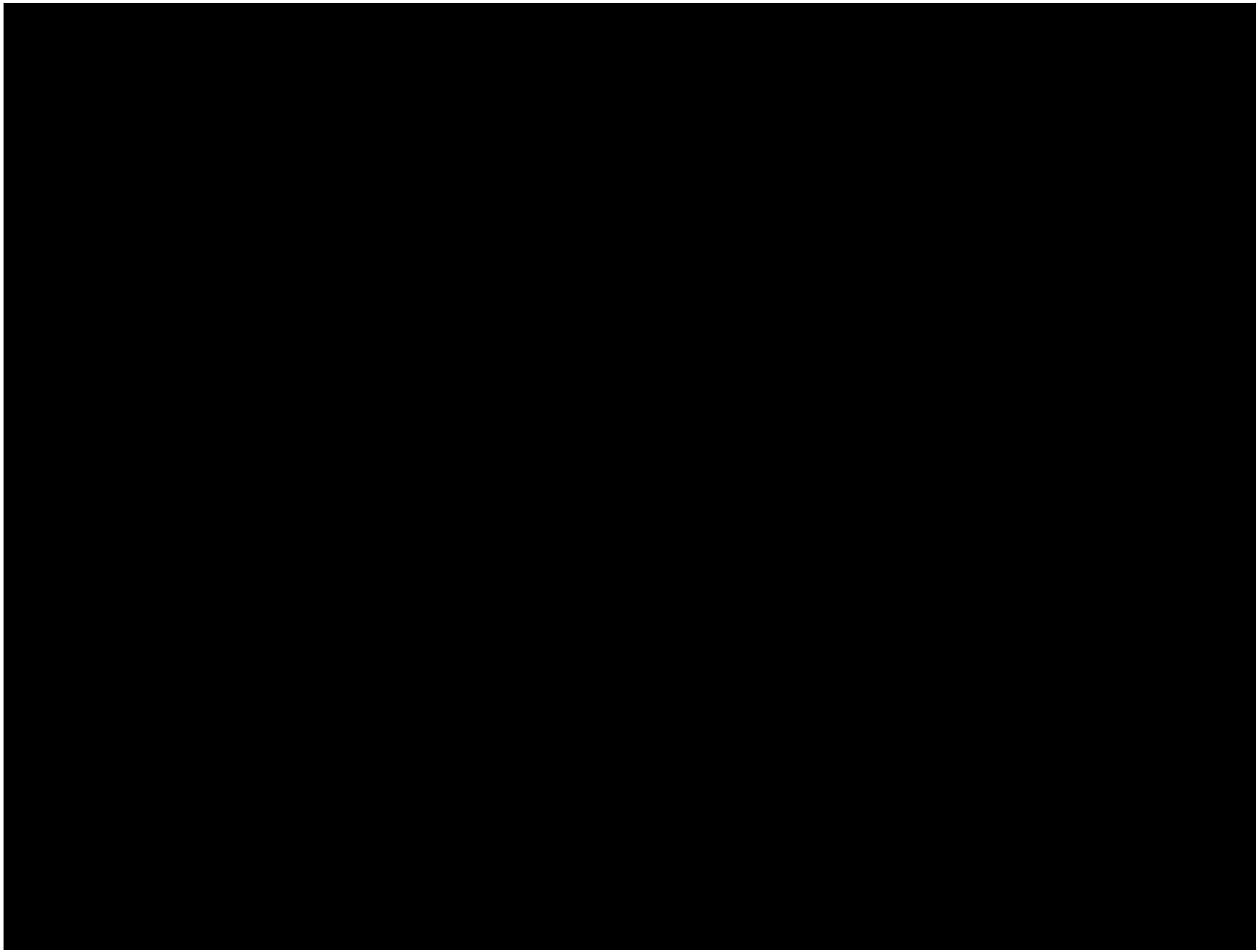


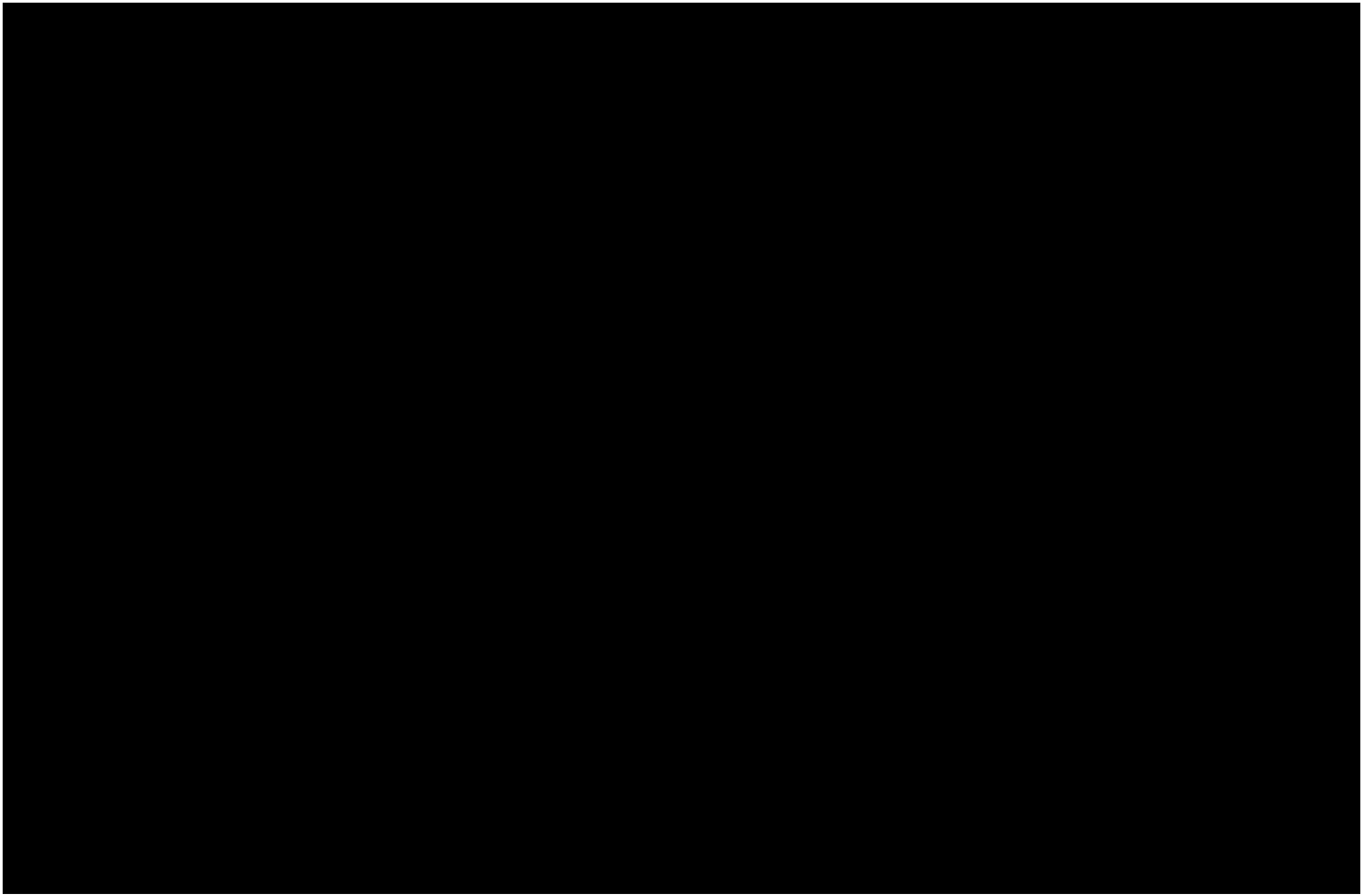


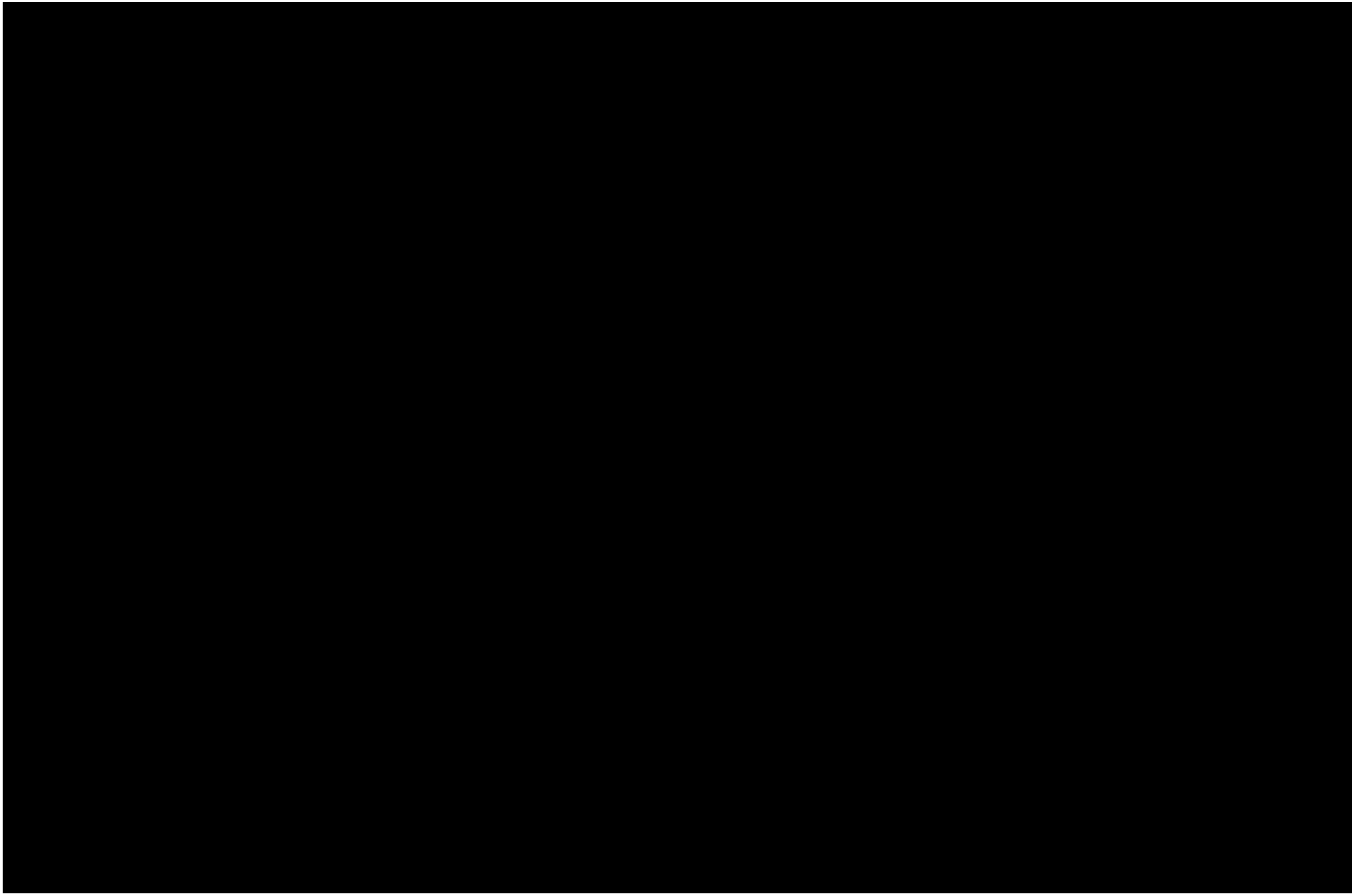












Improving Health Outcomes for Children

Healthy Blue contributes to Omaha Healthy Kids Alliance's mission to strengthen quality of life for children in Omaha.

Attachment V.J.43-1: Sample Provider Education and Training Materials

Healthy Blue

Attachment V.J.43-1: Sample Provider Education and Training Materials

Attachment V.J.43-1 includes the following:

- V.J.43-1a: Caring for Diverse Populations Toolkit Sample
- V.J.43-1b: Healthy Blue New Provider Orientation Sample
- V.J.43-1c: Provider Coding Education (CME/CEU) Registration Flyer Sample

Caring for Diverse Populations

Better communication, better care:
A toolkit for physicians and health care professionals

Healthy Blue | HERITAGE HEALTH

Table of contents

Introduction for health care professionals:
Why was this toolkit created? How can it help my practice?

This set of materials was produced by a team of health care professionals from across the country who, like you, is dedicated to providing quality, effective and compassionate care to their patients. Changes in U.S. demography, in our awareness of differences in individual belief and behavior, and new legal mandates continuously present new challenges to deliver access to health care to a diverse patient population. This toolkit was developed to provide you with resources to help address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates.

The toolkit contents are organized into several sections, each containing helpful background information and tools that can be reproduced and used as needed. Here is a list of the section topics, including a section overview and a small sample of the contents:

Resources to assist with a diverse patient population base:

The communication strategies suggested in this section are intended to minimize patient-provider and patient-office staff miscommunications and foster an environment that is nonthreatening and comfortable to the patient. We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. This section includes tips for providers and their clinical staff, a mnemonic to assist with diverse patient interviews, help in identifying literacy problems, an interview guide for hiring clinical staff with awareness of cultural competency issues, and *Americans with Disabilities Act (ADA)* requirements.

Resources to communicate across language barriers:

This section offers resources to help health care providers identify the linguistic needs of their limited English proficient (LEP) patients and strategies to meet their communication needs. Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services, which can lead to poor health outcomes and longer hospital stays. This section contains tools to help improve the linguistic competence of health care providers, including tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards and an employee language prescreening tool.

Resources to increase awareness of how cultural background impacts health care delivery:

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The tools in this section are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. Section content includes tips for talking with a wide range of people across cultures about a variety of culturally sensitive topics and information about health care beliefs of various cultural backgrounds.

Regulations and standards for cultural and linguistic services:

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care. This section includes key legal requirements such *45 CFR 92 – Nondiscrimination Rule*, and a summary of the *Culturally and Linguistically Appropriate Service (CLAS) Standards*, which serve as a guide on how to meet legal requirements, as well as race/ethnicity/language categories.

Resources for cultural and linguistic services:

This section contains web-based resources for more information related to diversity, cultural competency and the delivery of cultural and linguistic services, resources for conducting an assessment of the cultural and linguistic needs of your practice's patient population, and links to additional tools in multiple languages and/or written for LEP.

This toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistics Workgroup, a "volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public." More information on the ICE Workgroup may be obtained at **www.iceforhealth.org**.

Improving communications with a diverse patient base

Tips for successful encounters with diverse patients

To enable effective patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of speech

People vary greatly in length of time between comment and response, the speed of their speech and their willingness to interrupt:

- Tolerate gaps between questions and answers. Impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make him or her more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended when a patient interrupts you if no offense is intended.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye contact

The way people interpret various types of eye contact can be tied to cultural background and life experience.

- Most non-Hispanic Whites expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures, direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If patients seem uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body language

Sociologists say that 80% of communication is nonverbal. The meaning of body language varies greatly by culture, class, gender and age:

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently guide patient conversation

English predisposes us to a direct communication style; however, other languages and cultures differ:

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how he or she would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with yes or no. Research indicates that when patients, regardless of cultural background, are asked, "Do you understand?" many will answer "Yes," even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

Tips for providers and office staff to enhance communication with diverse patients

Recognize that patients from diverse backgrounds may have different communication needs.

Build rapport with the patient.

- Address patients by their last names. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language like *hello* and *thank you*.
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain to the patient the different roles performed by people who work in the office.

Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider arranges for care (when the provider is the first point of contact and then refers to specialists).
- Have instructions translated by a professional translator and available in the common language(s) spoken by your patient base.

Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the provider, review health materials or view waiting room videos.

Work to build patients' trust in you.

- Inform patients of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times.

Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have a plan for interpreter access. An interpreter with a medical background is preferred, rather than family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (See *Employee Language*.)
- Resources for interpreter services are available from health plans, the state health department and the internet.

Recognize that patients from diverse backgrounds may have different communication needs.

Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base.
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss.

Make sure patients know what to do.

- Review any follow-up procedures with the patient and family before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop preprinted simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base.

  Note: See commonly used sentences and signs provided in this toolkit.

Nonverbal communication and patient care

Nonverbal communication is a subtle form of communication that takes place in the initial three seconds upon meeting someone for the first time and continues through the entire interaction. Research indicates that nonverbal communication accounts for approximately 70% of a communication episode. Nonverbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face and how space is used. Yet we are rarely aware of how persons from other cultures may perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of nonverbal miscommunication that may sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently:

- A **stereotype** is an ending point. No attempt is made to learn whether the individual in question fits the statement.
- A **generalization** is a beginning point. It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

> Generalizations can serve as a guide to be accompanied by individualized, in-person assessment. As a rule, ask the patient rather than assume you know the patient's needs and wants.

If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye contact

Ellen was trying to teach her Navajo patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may also be considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and use of space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well-woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is understood, prior to the initiation of the examination. Ease into the patient's personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

A non-Hispanic white patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body posture and presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his provider visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family — the clothes are pressed, the hair is combed and shoes are clean. A person's physical presentation is not an indicator of his or her economic situation.

Use of voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health-related questions of his Vietnamese patient, Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question, he couldn't get Tanya to take an active part in the visit.

The use of voice is perhaps one of the most difficult forms of nonverbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loudly or too softly for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. The best suggestion is to search for nonverbal cues to determine how your voice is affecting your patient.

D-I-V-E-R-S-E — a mnemonic for patient encounters

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history.

	Assessment	Sample questions	Assessment information/ recommendations
D	**Demographics —** *Explore regional background, level of acculturation, age and sex as they influence health care behaviors.*	• Where were you born? • Where was home before coming to the U.S.? • How long have you lived in the U.S.? • What is the patient's age and sex?	
I	**Ideas —** *Ask the patient to explain his/her ideas or concepts of health and illness.*	• What do you think keeps you healthy? • What do you think makes you sick? • What do you think is the cause of your illness? • Why do you think the problem started?	
V	**Views of health care treatments —** *Ask about treatment preference, use of home remedies and treatment avoidance practices.*	• Are there any health care procedures that might not be acceptable? • Do you use any traditional or home health remedies to improve your health? • What have you used before? • Have you used alternative healers? Which? • What kind of treatment do you think will work?	
E	**Expectations —** *Ask about what your patient expects from his/her provider.*	• What do you hope to achieve from today's visit? • What do you hope to achieve from treatment? • Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion —** *Ask about your patient's religious and spiritual traditions.*	• Will religious or spiritual observances affect your ability to follow treatment? How? • Do you avoid any particular foods? • During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech —** *Identify your patient's language needs, including health literacy levels. Avoid using a family member as an interpreter.*	• What language do you prefer to speak? • Do you need an interpreter? • What language do you prefer to read? • Are you satisfied with how well you read? • Would you prefer printed or spoken instructions?	
E	**Environment —** *Identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	• Do you live alone? • How many other people live in your house? • Do you have transportation? • Who gives you emotional support? • Who helps you when you are ill or need help? • Do you have the ability to shop/cook for yourself? • What times of day do you usually eat? • What is your largest meal of the day?	

Tips to identify and address health literacy issues

Low health literacy can prevent patients from understanding their health care services.

Health literacy is defined by the National Health Education Standards as "the capacity of an individual to obtain, interpret, and understand basic health information and services, and the competence to use such information and services in ways which are health-enhancing." This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, providers' directions, consent forms and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to years of education. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment.

Barriers to health literacy

- The ability to read and comprehend health information is impacted by a range of factors, including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of an accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures, it is inappropriate for people to discuss certain body parts or functions, leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6 to 12 years to develop.

Possible signs of low health literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behavior may include:

- Not getting their prescriptions filled or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Tips for dealing with low health literacy

- Use simple words and avoid jargon.
- Never use acronyms.
- Avoid technical language (if possible).
- Repeat important information — A patient's logic may be different from yours.
- Ask patients to repeat back to you important information.
- Ask open-ended questions.
- Use medically trained interpreters familiar with cultural nuances.
- Give information in small chunks.
- Articulate words.
- Read written instructions out loud.
- Speak slowly (don't shout).
- Use body language to support what you are saying.
- Draw pictures; use posters, models or physical demonstrations.
- Use video and audio media as an alternative to written communications.

Health literacy is not the same as the ability to read and is not necessarily related to years of education. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment.

Additional resources

Use Ask Me 3®.* Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3®, please visit **http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx.**

Ask Me 3® is a registered trademark licensed to the Institute of Healthcare Improvement.

Planning effective written patient communications

All medical offices should have written communication campaigns for their diverse patient base, whether it is to announce business operation changes, or health improvement reminders about routine vaccinations or the importance of preventive health screenings.

Here are some tips to help increase the effectiveness of your office's written communication campaign. When developing your message, think through what you expect the outcome to be. Ask:

- Who is your target audience?
- What is the objective of the communication?
- What does a patient need to know to get the result you want?
- What is the call to action or the desired behavior?
- How will you best clarify the benefit of taking this action?

If yours is a more targeted mailing campaign, think about gender, age, stage of life (single, family, and empty nesters), geography, the type of insurance coverage and even race/ethnicity, where appropriate.

We conducted extensive research with racial and ethnic minority group patients. The results demonstrated that the most effective communication materials that engaged patients and induced action shared several key elements. These themes are integral components of culturally relevant communication initiatives.

We call these themes the *Five Fs:* food, family, faith, fear and finances

- **Food:** affinity to cultural foods and difficulties in changing dietary habits
- **Family:** particularly *being* there for children and grandchildren
- **Faith and spirituality:** respecting life as a gift; recognizing faith-based entities as trusted sources of health information
- **Fear:** disease complications, especially amputations, blindness and kidney disease, or myths regarding adverse outcomes from treatments
- **Finances:** affordability of health care and healthy lifestyles (for example, food, gym membership, testing strips and copays)

While all these themes may not always be relevant to a specific communication topic, framing the benefits to the patient — from defining a call to action to weaving in culturally appropriate and sensitive discussions of the relevant Five Fs themes — may help your message resonate more effectively with your diverse patient base.

Tools and training for your office in caring for a diverse patient base

Interview guide for hiring office/clinic staff with diversity awareness

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation and trust between patients and staff. Remember that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

Sample interview questions

Q: What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q: In the health care field, we come across patients of different ages, language preferences, sexual orientations, religions, cultures, genders and immigration status, etc. all with different needs. What skills from your past customer service or community/health care work do you think are relevant to this job?

This question should allow a better understanding of the interviewee's approach to customer service across the spectrum of diversity, his or her previous experience, and if his or her skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q: What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

Americans with Disabilities Act (ADA) requirements

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit http://www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the *ADA* for Title II (state and local government services) and Title III (public accommodations and commercial facilities) on September 15, 2010, in the *Federal Register*. These requirements or rules clarify and refine issues that have arisen over the past 20 years and contain new and updated requirements, including the *2010 Standards for Accessible Design (2010 Standards*).

Effective communication

Overview

People who have vision, hearing or speech disabilities (*communication disabilities*) use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing, and people who are deaf may give and receive information through writing or sign language rather than through speech.

The *ADA* requires that Title II entities (state and local governments) and Title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help Title II and Title III entities (*covered entities*) understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them:

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from and convey information to the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity and context of the communication, and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

Auxiliary aids and services

The *ADA* uses the term auxiliary aids and services (*aids and services*) to refer to the ways to communicate with people who have communication disabilities:

- For people who are blind, have vision loss or are deaf-blind, this includes providing a *qualified* reader; information in large print, Braille or electronically for use with a computer screen-reading program; or an audio recording of printed information. A qualified reader means someone who is able to read effectively, accurately and impartially using any necessary specialized vocabulary. using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A *qualified* interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (for example, understanding what the person with the disability is saying) and expressively (for example, having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly), especially if the person will be speaking at length, such as giving testimony in court or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies, such as:

- Assistive listening systems and devices.
- Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices.
- Telephone handset amplifiers, hearing-aid compatible telephones, text telephones (TTYs), videophones, captioned telephones and other voice, text, and video-based telecommunications products.
- Videotext displays.
- Screen reader software, magnification software and optical readers.
- Video description and secondary auditory programming devices that pick up video-described audio feeds for television programs.
- Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

Effective communication provisions

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key. For example:

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through telecommunication relay services (TRS) and video relay services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

Companions

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress.
- Hospital staff often talks to a patient's spouse, other relative or friend about the patient's condition or prognosis.

The rules refer to such people as *companions* and require covered entities to provide effective communication for companions who have communication disabilities. The term *companion* includes any family member, friend or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

Use of accompanying adults or children as interpreters

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The *ADA* places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations:

1. In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.
2. In situations not involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does not apply to minor children.

Even under exception two, covered entities may not rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

Who decides which aid or service is needed?

When choosing an aid or service, Title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are encouraged to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the *ADA*, please visit the website or call the toll-free number:

- **www.ada.gov**
- *ADA* Information Line: **1-800-514-0301** (voice) and **1-800-514-0383** (TTY)

Examples of effective communication

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from and convey information to the covered entity (physician office, clinic, hospital, nursing home, etc.). Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because of...	These are some options you can offer...
Visual impairments or blindness that keep them from reading	• Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped: **https://www.loc.gov/nls/pdf/application.pdf** • Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Hearing impairments that impact ability to understand directions	• Amplifier/pocket talker • Written materials • Qualified sign language interpreter • Qualified note taker • Telecommunications Relay Services (TRS) — **711** • Have physician dictate into voice-recognition software and patient can type answers back
Difficulty speaking clearly and making themselves understood	• Allow for extra time and attentive listening • Qualified note taker • TRS — **711** • Communication board or paper and pencil • Have physician dictate into voice-recognition software and patient can type answers back

All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Supporting patients with 211 and 711 community services

211* and 711* are free and easy-to-use services that can be used as resources to support patients with special needs. Each of these services operates in all states and is offered at no cost to the caller 24 hours a day, 7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, go to **www.211.org.**

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The **711** relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and TRS users can initiate a call from any telephone anywhere in the United States without having to remember and dial a seven or ten-digit access number.

Simply dial **711** to be automatically connected to a TRS operator. Once connected, the TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, **711** offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit **http://ddtp.cpuc.ca.gov/homepage.aspx.**

Resources to communicate across language barriers

Developing a language service plan

Language services can be the key to patient engagement. Unaddressed language barriers can negatively impact patient satisfaction, quality of care and health outcomes. To ensure your office is effectively meeting the needs of your LEP patients, your office can develop a language service plan.

Where to start

Get ready!

- Identify a designee or small team and commit to improve your capacity to serve individuals with LEP.
- Identify the most common languages of LEP patients you serve.
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials.
- Document what needs to be enhanced.

Get set!

- Review available language resources and identify those most useful for your office.

Go!

- Create, implement and evaluate your plan.
- Provide staff training on the language service plan and cultural competency.

This section of the toolkit contains information you can use to help develop your plan, such as identifying preferred languages of your patients, tips for communicating across language barriers and tips for locating and working with interpreters. Additional resources are available at the end of this toolkit to help you complete your language service plan.

Tips for working with LEP patients

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English, may be considered LEP.

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions.
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member self identifies as LEP by requesting language assistance.

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language.
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
  - Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

How to offer interpreter services:

"I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?"

or

"May I put you on hold? I am going to connect us with an interpreter." (If you are having a difficult time communicating with the member.)

Best practice to capture language preference

For LEP members, it is a best practice to capture the members preferred language and record it in the plan's member data system.

"In order for me (Healthy Blue) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"

Tips for communicating across language barriers

LEP patients are faced with language barriers that undermine their ability to understand information given by health care providers, as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, provider directions and consent forms. They experience more difficulty than other patients processing information necessary to care for themselves and others.

Tips to identify a patient's preferred language

- Ask the patient for his or her preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.
- Post information relative to the availability of interpreter services.
- Make available and encourage patients to carry I speak... or language ID cards. Note: Many phone interpreter companies provide language posters and cards at no charge.

Tips to document patient language needs

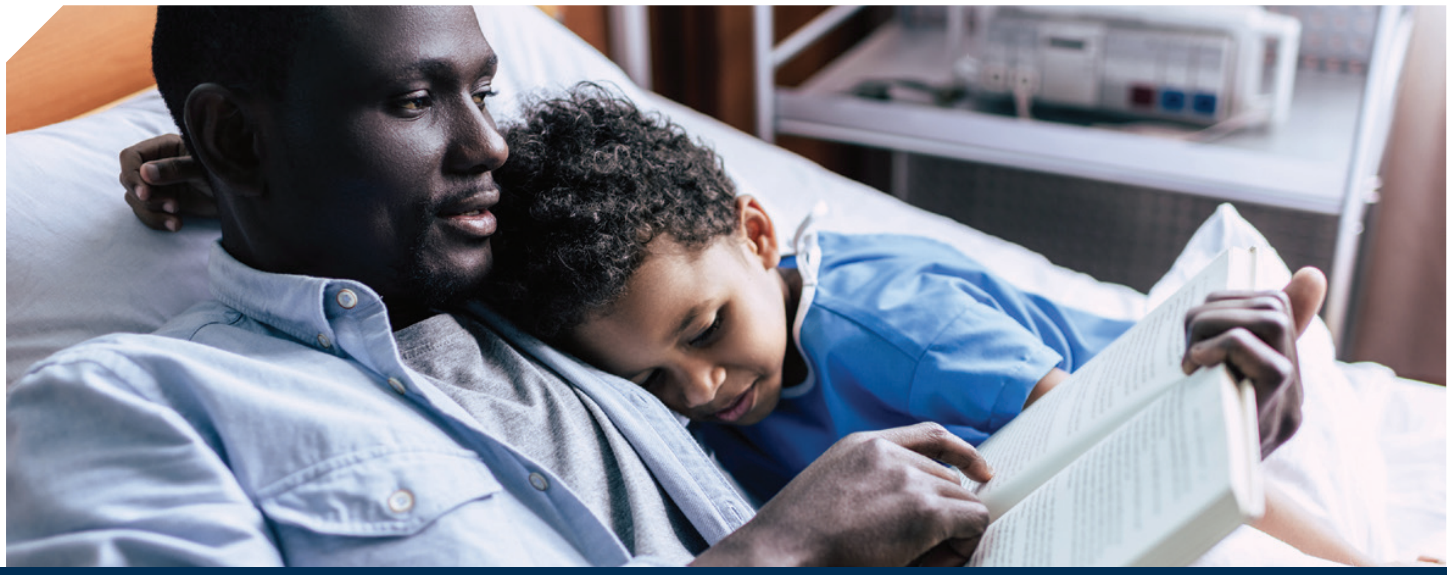
- For all LEP patients, document preferred language on paper and/or in electronic medical records.
- Post color stickers on the patient's chart to flag when an interpreter is needed (for example, orange for Spanish, yellow for Vietnamese and green for Russian).

Tips to assess which type of interpreter to use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to overcome language barriers

- Use simple words; avoid jargon and acronyms.
- Limit or avoid technical language.
- Speak slowly (don't shout).
- Articulate words completely.
- Repeat important information.
- Use pictures, demonstrations, video or audiotapes to increase understanding.
- Give information in small chunks and verify comprehension before going on.
- Always confirm that the patient understands the information — the patient's logic may be different from yours.
- Provide educational material in the languages your patients read.



Tips for working with interpreters

Telephonic interpreters

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey.
- Reassure the patient that the information will be kept confidential.
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, for example, *can't — cannot*.
- Speak in short sentences, expressing one idea at a time.
- Speak slower than your normal speed of talking, pausing after each phrase.
- Avoid the use of double negatives, for example, "If you don't appear in person, you won't get your benefits."
  - Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the *he said/she said*.
- Avoid using colloquialisms and acronyms, for example, *MFIP*. If you must do so, please explain their meaning.
- Provide brief explanations of technical terms, or terms of art, for example, *spend-down* means the client must use up some of his/her monies or assets in order to be eligible for services.
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client.
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.
- **Above all, be patient** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service.
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is blind to the visual cues in the room. The following will help the interpreter do a better job.

When the interpreter comes onto the line, let the interpreter know the following:

- Who you are.
- Who else is in the room.
- What sort of office practice this is.
- What sort of appointment this is. For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam."
- Give the interpreter the opportunity to introduce himself or herself quickly to the patient.
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.

On-site interpreters

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For face-to-face interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For American Sign Language interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the person who is deaf or hard of hearing. This makes it easy for the person with the hearing impairment to see you and the interpreter in their line of sight.
- Be aware of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- Be attentive to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, *yes* may not always mean *yes*. Instead, *yes* might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment or simply a polite way of declining to give a definite answer at that juncture.
- Greet the patient first, not the interpreter.
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today."
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: for example, "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's voice most accurately and deal with the patient directly.
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult.
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything.
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter.
- Speak in standard English (avoid slang). Use:
  - Layman's terms (avoid medical terminology and jargon).
  - Straightforward sentence structure.
  - Complete sentences and ideas.

- Ask one question at a time.
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message.
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech.
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education.
- Acknowledge the interpreter as a professional in communication. Respect his or her role.

Tips for locating interpreter services

First, identify the languages spoken by your patients. Second, assess the services available to meet these needs.

Assess the language capability of your staff (See *Employee Language Prescreening Tool.*)

- Keep a list of available certified bilingual staff that can assist with LEP patients onsite.
- Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are *HIPAA* compliant.

- **Do not** rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- **Do not** rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.

Keep an updated list of specific telephone numbers and health plan contacts for language services.

Identify available language services.

- **Do not** require an individual with LEP to provide his/her own interpreter.
- Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.
  - If face-to-face interpreters are covered, have the following information ready before requesting the interpreter: gender, age, language needed, date/time of appointment, type of visit and office specialty.
  - If telephone interpreters are covered, relay the pertinent patient information which will help the interpreter better serve the needs of the patient and the provider.
- Identify community based qualified interpreter resources.
- Create and provide to your staff policies and procedures to access interpreter services.
- Keep an updated list of specific telephone numbers and health plan contacts for language services.
- If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.
- **711** relay services are available to assist in basic communication with patients who are deaf or hard of hearing. In some areas services to communicate with speech impaired individuals may also be available.

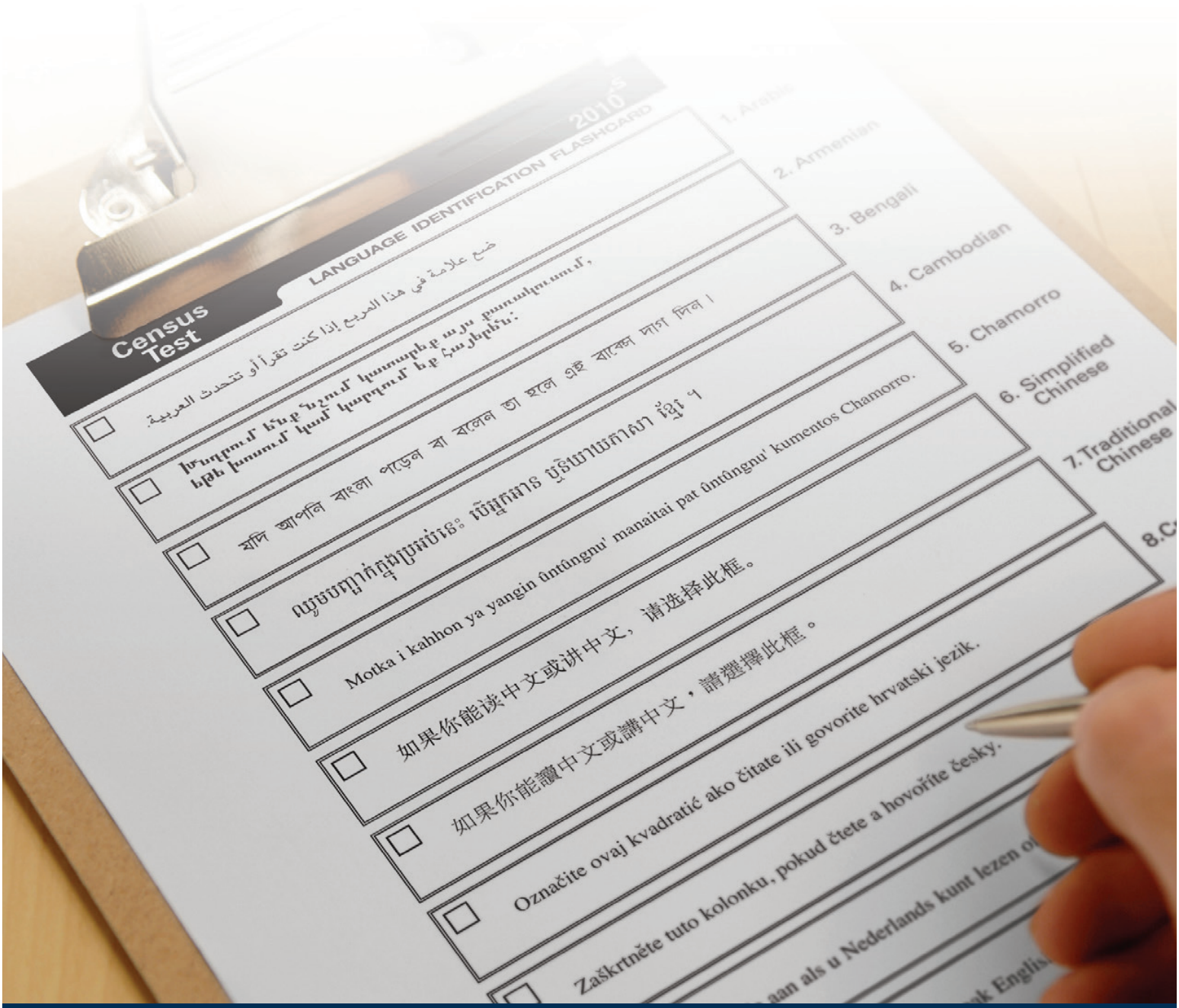
Note: Remember to follow all *HIPAA* regulations when transmitting any patient-identifiable information to parties outside your office.

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local health care interpreters association in your area.

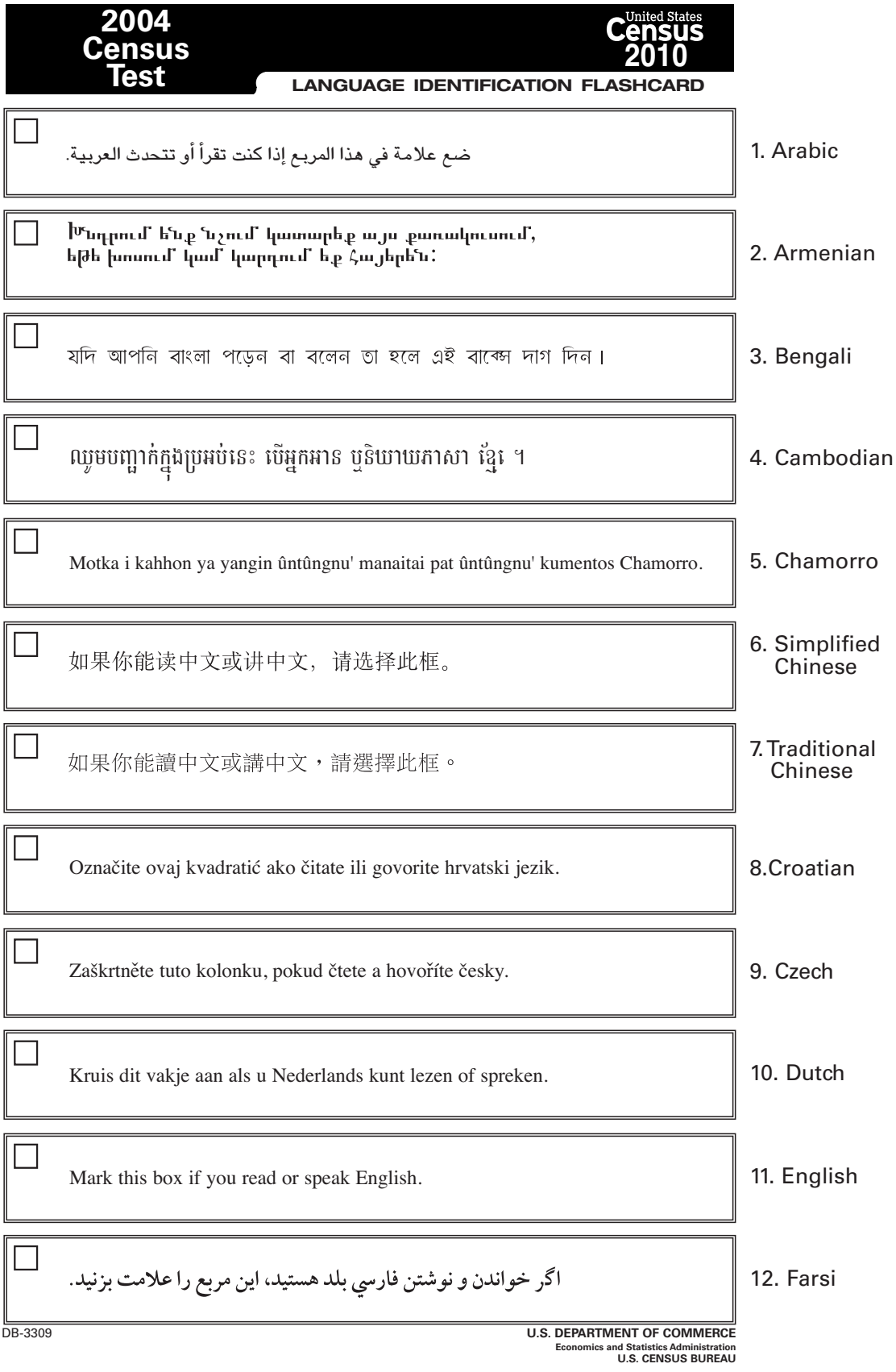
U.S. Census Bureau language identification flashcards

The sheets on the following pages can be used to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to the patient to read the other languages, and point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in his or her medical record.

The language identification flashcards were developed by the U.S. Census Bureau and can be used to identify most languages that are spoken in the United States.



U.S. Census Bureau 2010 language identification flashcards



Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

U.S. Census Bureau 2010 language identification flashcards

☐ Cocher ici si vous lisez ou parlez le français.	13. French
☐ Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen.	14. German
☐ Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά.	15. Greek
☐ Make kazye sa a si ou li oswa ou pale kreyòl ayisyen.	16. Haitian Creole
☐ अगर आप हिन्दी बोलते या पढ़ सकते हों तो इस बक्स पर चिह्न लगाएँ।	17. Hindi
☐ Kos lub voj no yog koj paub twm thiab hais lus Hmoob.	18. Hmong
☐ Jelölje meg ezt a kockát, ha megérti vagy beszéli a magyar nyelvet.	19. Hungarian
☐ Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano.	20. Ilocano
☐ Marchi questa casella se legge o parla italiano.	21. Italian
☐ 日本語を読んだり、話せる場合はここに印を付けてください。	22. Japanese
☐ 한국어를 읽거나 말할 수 있으면 이 칸에 표시하십시오.	23. Korean
☐ ໃຫ້ໝາຍໃສ່ຊ່ອງນີ້ ຖ້າທ່ານອ່ານຫຼືປາກພາສາລາວ.	24. Laotian
☐ Prosimy o zaznaczenie tego kwadratu, jeżeli posługuje się Pan/Pani językiem polskim.	25. Polish

DB-3309

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

U.S. Census Bureau 2010 language identification flashcards

☐ Assinale este quadrado se você lê ou fala português.	26. Portuguese
☐ Însemnaţi această căsuţă dacă citiţi sau vorbiţi româneşte.	27. Romanian
☐ Пометьте этот квадратик, если вы читаете или говорите по-русски.	28. Russian
☐ Обележите овај квадратић уколико читате или говорите српски језик.	29. Serbian
☐ Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	30. Slovak
☐ Marque esta casilla si lee o habla español.	31. Spanish
☐ Markahan itong kuwadrado kung kayo ay marunong magbasa o magsalita ng Tagalog.	32. Tagalog
☐ ให้กาเครื่องหมายลงในช่องถ้าท่านอ่านหรือพูดภาษาไทย.	33. Thai
☐ Maaka 'i he puha ni kapau 'oku ke lau pe lea fakatonga.	34. Tongan
☐ Відмітьте цю клітинку, якщо ви читаєте або говорите українською мовою.	35. Ukranian
☐ اگر آپ اردو پڑھتے یا بولتے ہیں تو اس خانے میں نشان لگائیں۔	36. Urdu
☐ Xin đánh dấu vào ô này nếu quý vị biết đọc và nói được Việt Ngữ.	37. Vietnamese
☐ באצייכנט דעם קעסטל אויב איר לייענט אדער רעדט אידיש.	38. Yiddish

DB-3309

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

Source: U.S. Department Of Commerce Economics and Statistics Administration U.S. Census Bureau

Common signs in multiple languages

English, Spanish, Vietnamese and Chinese

You may wish to use this tool to mark special areas in your office to help your LEP patients. It is suggested you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中 文	*Chinese*	歡 迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中 文	*Chinese*	登 記 處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中 文	*Chinese*	收 銀 部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中 文	*Chinese*	入 口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中 文	*Chinese*	出 口

English		Restroom
Español	*Spanish*	Baños
Tiếng Việt	*Vietnamese*	Phòng vệ sinh
中 文	*Chinese*	洗 手 間

Common sentences in multiple languages

English-Spanish-Vietnamese-Chinese

This tool is designed for office staff to assist in basic entry-level communication with limited LEP patients. Point to the sentence you wish to communicate and your LEP patient may read it in his/her language of preference. The patient can then point to the next message.

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	指向句子
Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	指向句子
Courtesy statements	*Frases de cortesía*	*Từ ngữ lịch sự*	*禮貌敘述*
Please wait.	Por favor espere (un momento).	*Xin vui lòng chờ.*	請等等
Thank you.	Gracias.	*Cám ơn.*	多謝
One moment, please.	Un momento, por favor.	*Xin đợi một chút.*	請等一會
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	指向句子
Patient may say...	*El paciente puede decir...*	*Bệnh nhân có thể nói...*	*病人可能會說…*
My name is...	Mi nombre es...	*Tôi tên là...*	我的名字是…
I need an interpreter.	Necesito un intérprete.	*Chúng tôi cần thông dịch viên.*	我需要一位傳譯員…
I came to see the doctor because...	Vine a ver al doctor porque ...	*Tôi muốn gặp bác sĩ vì...*	我來見醫生是因為...
I don't understand.	No entiendo.	*Tôi không hiểu.*	我不明白
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	*Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.*	請盡快，這是非常緊急。
Where is the bathroom?	¿Dónde queda el baño?	*Phòng vệ sinh ở đâu?*	洗手間在那裏？
How much do I owe you?	¿Cuánto le debo?	*Tôi cần phải trả bao nhiêu tiền?*	我欠您多少錢？
Is it possible to have an interpreter?	¿Es posible tener un intérprete?	*Có thể nhờ một thông dịch viên đến giúp chúng ta không?*	可否找一位傳譯員？

English	Spanish / Español	Vietnamese / Tiếng Việt	Chinese / 中文
Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	指向句子
Staff may ask or say...	*El personal del médico le puede decir...*	*Nhân viên có thể hỏi hoặc nói*	*職員可能會問或說...*
How may I help you?	¿En qué puedo ayudarle?	*Tôi có thể giúp được gì?*	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	*Tôi không hiểu.* *Xin đợi một chút.*	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	*Quí vị thích dùng ngôn ngữ nào?*	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	*Chúng tôi sẽ gọi thông dịch viên*	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	*Sẽ có một thông dịch viên đến giúp chúng ta.*	傳譯員就快到。
What is your name?	¿Cuál es su nombre?	*Qúy vị tên gì?*	您叫什麼名字？
Who is the patient?	¿Quién es el paciente?	*Ai là bệnh nhân?*	誰是病人？
Please write **the patient's:**	Por favor escriba, acerca **del paciente:**	*Xin viết lý lịch của bệnh nhân:*	請寫出病人的：
Name	Nombre	*Tên*	姓名
Address	Dirección	*Địa Chỉ*	地址
Telephone number	Número de teléfono	*Số Điện Thoại*	電話號碼
Identification number	Número de identificación	*Số ID*	醫療卡號碼
Birth date:	Fecha de nacimiento:	*Ngày Sinh:*	出生日期：
Month/Day/Year	Mes/Día/Año	*Tháng/Ngày/Năm*	月/日/年
Now, fill out these forms, please.	Ahora, por favor conteste estas formas.	*Bây giờ xin điền những đơn này.*	*現在，請填寫這表格*

English-Spanish-French Creole

This tool is designed for office staff to assist in basic entry-level communication with LEP patients. Point to the sentence you wish to communicate and your LEP patient may read it in his/her language of preference. The patient can then point to the next message.

English	Spanish/Español	Creole/Kreyòl
👇 **Point to a sentence**	👇 **Señale una frase**	👇 **Lonje dwèt ou sou yon fraz**
Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*
👇 **Point to a sentence**	👇 **Señale una frase**	👇 **Lonje dwèt ou sou yon fraz**
Courtesy statements	*Frases de cortesía*	*Pawòl pou Koutwazi*
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman).
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
👇 **Point to a sentence**	👇 **Señale una frase**	👇 **Lonje dwèt ou sou yon fraz**
Patient may say...	*El paciente puede decir...*	*Pasyan an kapab di...*
My name is...	Mi nombre es...	Non mwen se...
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt.
I came to see the doctor because...	Vine a ver al doctor porque...	Mwen vin wè doktè a, paske...
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	¿Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	¿Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	¿Es posible tener un intérprete?	Èske mwen ka gen yon entèprèt?

English	Spanish/Español	Creole/Kreyòl
Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**
Staff may ask or say...	*El personal del médico le puede decir...*	*Anplwaye medikal la kapab di oubyen mande...*
Please hold. I will be right back.	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka fè pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon entèprèt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon entèprèt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?
Please write **the patient's:**	Por favor escriba, acerca **del paciente:**	Tanpri, ekri enfòmasyon sa yo **pou pasyan an:**
Name	Nombre	Non
Address	Dirección	Adrès
Telephone number	Número de teléfono	Nimewo telefòn
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month/Day/Year	Mes/Día/Año	Mwa/Jou/Ane
Now, fill out these forms, please.	Ahora, por favor conteste estas formas.	Kounye a, ekri enfòmasyon yo mande nan papye sa yo.

Employee language prescreening tool

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment. The screening tool is not meant to serve as an assessment for qualified medical interpreters or meet legal or regulatory requirements.

Once bilingual staff has been identified, they should be referred to professional assessment agencies to evaluate the level of proficiency. There are many sources that will help you assess the bilingual capacity of staff. Depending on their level of confirmed fluency, your practice would be able to make use of this added value to help your practice better communicate with your patients in the client's language of preference. As a recommendation, staff providing interpreter support should receive training on and adhere to the National Standards of Practice for Interpreters in Health Care.

We recommend that you distribute the tool to all of your clinical and nonclinical employees using their non-English language skills in the workplace. The information collected may be used as a first step to improve communication with your diverse patient base. You may wish to write an introductory note along the following lines:

We are committed to maintaining our readiness to serve the needs of our patients. Many of our employees could use their skills in languages other than English. We are compiling information about resources available within our work force.

Please complete and return this prescreening tool to <department/contact> no later than <date>. The responses will not affect your performance evaluation. It is just a way for us to improve our customer service, and to make you a part of such efforts.

Thank you for your assistance.

Employee language prescreening tool (for clinical and nonclinical employees)

Thank you for participating in this survey process. This prescreening tool is intended for clinical and nonclinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee name: _____

Department/job title: _____

Work days: Mon/Tues/Wed/Thurs/Fri/Sat/Sun

Work hours (please specify): _____

Directions:

1. Write all language(s) or dialects you know.
2. Indicate how fluently you speak, read and/or write each language (see attached key).

E X A M P L E

Language	Dialect, region...	Speaking	Reading	Writing	Do you speak...	Do you read...	Do you write...
Spanish	Mexico	①2 3 4 5	1②3 4 5	①2 3 4 5	Yes (No)	(Yes) No	Yes (No)

Language	Dialect, region or country	Fluency: see attached key (Circle)			As part of your job, do you use this language to speak with patients? (Circle)	As part of your job, do you read this language? (Circle)	As part of your job, do you write this language? (Circle)
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

Employee language prescreening tool key

Key for spoken language capability	
Key	**Spoken Language**
1	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to two to three word entry-1 level questions. May require slow speech and repetition.
2	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school and family. Has difficulty with vocabulary and grammar.
3	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
4	Able to use the language fluently and accurately on all levels related to work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
5	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key for reading capability	
Key	**Reading**
1	No functional ability to read. Able to understand and read only a few key words.
2	Limited to simple vocabulary and sentence structure.
3	Understands conventional topics, nontechnical terms and health care terms.
4	Understands materials that contain idioms and specialized terminology; understands a broad range of literature.
5	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key for writing capability	
Key	**Writing**
1	No functional ability to write the language and is only able to write single elementary words.
2	Able to write simple sentences. Requires major editing.
3	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
4	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
5	Writes proficiently equivalent to that of an educated native speaker /writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, health care, academic and technical vocabulary.

Interpretation versus translation:

- Interpretation: Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor.
- Translation: Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original.

Resources to increase awareness of how cultural background impacts health care delivery

Health equity, health equality and health disparities

What does health equity mean?

Health equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group.
- Religion.
- Socioeconomic status.
- Gender.
- Age.
- Mental health.
- Cognitive, sensory or physical disability.
- Sexual orientation.
- Geographic location.
- Other characteristics historically linked to discrimination or exclusion.

Health disparities matter to all of us. Here are just two examples of what can happen when there are disparities...

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The difference between health equality and health equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division.

Health equity is different from health equality. The term refers specifically to **the absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control.

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled.

Health equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of CLAS is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that are **respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes. The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit **https://www.thinkculturalhealth.hhs.gov.**

Plans for achieving health equity and what you can do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into better health care.

Knowing your patients and making sure that you collect and protect specific data, for example their preferred spoken and written languages, can have a major impact on their care.

The website **https://www.thinkculturalhealth.hhs.gov**, sponsored by the Office of Minority Health (OMH), offers the latest resources and tools to promote cultural and linguistic competency in health care. **You may access free and accredited continuing education programs** as well as tools to help you and your organization provide respectful, understandable and effective services.

Who else is addressing health disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, health plans and government organizations. The *Affordable Care Act* required the establishment of OMHs within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality
- CDC
- CMS
- Food and Drug Administration
- Health Resources and Services Administration
- Substance Abuse and Mental Health Services Administration

These offices join the HHS OMH and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities.

Key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, **https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**
- Office of Minority Health at HHS, **http://minorityhealth.hhs.gov**
- Think Cultural Health, **https://www.thinkculturalhealth.hhs.gov**

Cultural background — information on special topics

Use of alternative or herbal medications

- People who have lived in poverty or come from places where medical treatment is difficult to get, will often come to the provider only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.
- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and *medicines* that are considered *folk medicine* or herbal medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are hard- to-find or that are purchased at *special stores* may get you a more accurate understanding of what people are using than asking about *alternative, traditional, folk or herbal medicine*.

> Some treatments and medicines that are considered folk medicine or herbal medications in the United States are part of standard medical care in other countries.

Pregnancy and breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact, it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant woman, which may not be a function of age.
- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures, there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latina women believe that colostrum (a fluid in the breasts that nourishes the baby until the breast milk becomes available) is not good for a baby. An explanation from the provider about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, *chubby* children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as thinness has in our culture — treat it as a cultural as well as a medical issue for better success.

Infant health

- It is very important to avoid making too many positive comments about a baby's general health:
  - Among traditional Hmong, saying a baby is *pretty* or *cute* may be seen as a threat because of fears that spirits will be attracted to the child and take it away.
  - Some traditional Latinos will avoid praise to avoid attracting the *evil eye*.
  - Some Vietnamese consider profuse praise as mockery.
- It is often better to focus on the quality of the mother's care (for example, "The baby looks like you take care of him well.")

Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well baby visits and checkups as a kind of extension of the immunization process.

Substance abuse

- When asking questions regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures, family loyalty, hierarchy and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.
- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues, the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies and should be discussed together with eating and other dietary issues.

Physical abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable here, and what may cause physical harm.
- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse not because of feelings of low self-esteem, but because it is socially accepted among their peers or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.
- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust providers, social workers or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (Silence may tell you more than misleading answers.). Using depersonalized conversational methods will increase success in reaching reluctant patients.
- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean anyone is being deceptive — just seeing things differently. This may cause special difficulties for teens that may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.
- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.
- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Be aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Be aware that many people believe giving a patient a terminal prognosis is unlucky, or will bring death sooner, and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines, the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case, you should not draw attention to this issue, but seek out other methods of communication.

Older adult communication needs from your patients' perspective	
I wish you knew...	**I wish you would...**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as honey, dear and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to patients who are hard of hearing. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible.
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan.
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand.	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

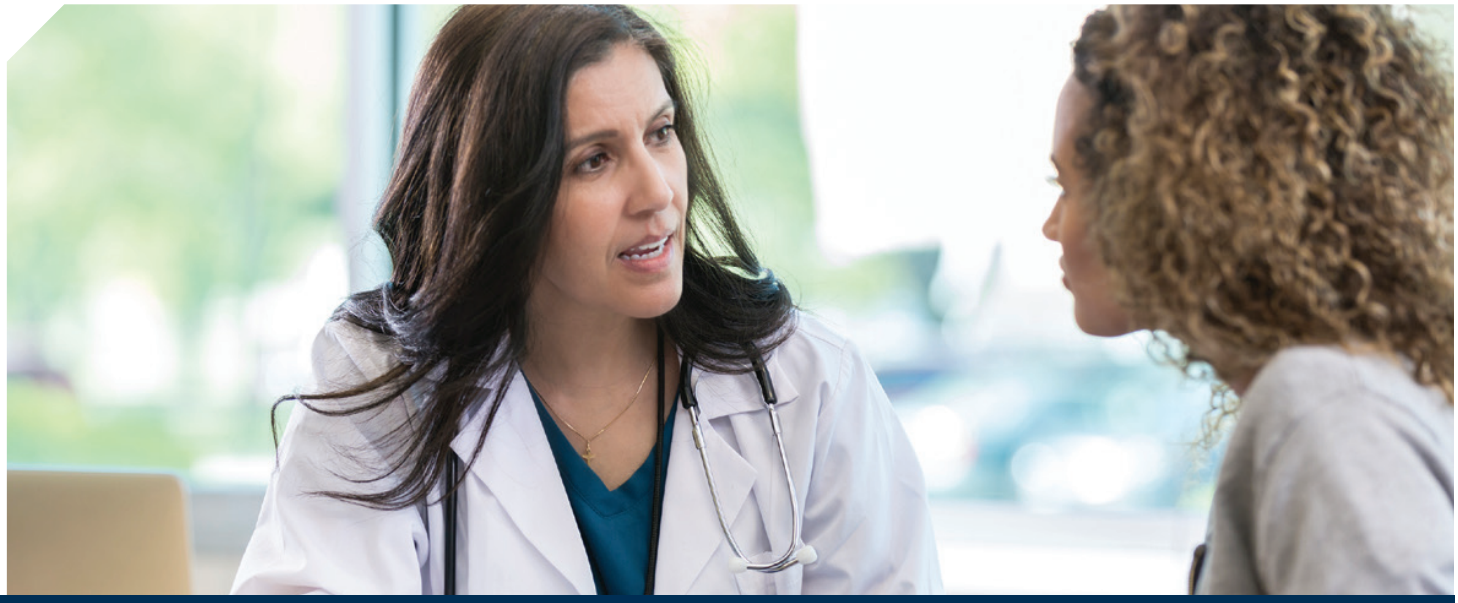
Talking about sex

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories. Areas of cultural variation points to consider are:

- Gender roles vary and change as the person ages (for example, women may have much more freedom to openly discuss sexual issues as they age).
- A patient may not be permitted to visit providers of the opposite sex unaccompanied (for example, a woman's husband or mother-in-law will accompany her to an appointment with a male provider).
- Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person.
- Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.
- Before entering the exam room, tell the patient and his or her companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam.
- As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and reassure the companion or guardian that the person will be in the room at all times.
- Use same-sex nonfamily members as interpreters.

Sexual health and patient cultural background

- If a sexual history is requested during a nonrelated illness appointment, patients may conclude the two issues — for example, blood pressure and sexual health — are related.
- In many health belief systems, there are connections between sexual performance and physical health that are different from the Western tradition. Example: Chinese males may discuss sexual performance problems in terms of a *weak liver*.
- Printed materials on topics of sexual health may be considered inappropriate reading materials.
- Explain to the patient why you are requesting sexually related information at that time.
- For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information.
- Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same gender as the patient.



Confidentiality preferences

- Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals of discomfort, or ask directly how they would like to proceed.
- A patient may be required to bring family members to his or her appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials.
- Be attentive to a patient's body language or comments that may indicate that he or she is uncomfortable discussing sexual health with a companion or guardian in the room.
- It may help to apologize for the need to ask sexual or personal questions, and explain the necessity.
- Try to offer the patient a culturally acceptable way to have a confidential conversation. Example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information."
- Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

Lesbian, gay, bisexual or transgender

Communities are made up of many diverse cultures, sexual orientations and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT) may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes. According to Healthy People 2020, LGBT health disparities include:

- Youth are two to three times more likely to attempt suicide and are more likely to be homeless.
- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- LGBT populations have the highest rates of tobacco, alcohol and other drug use.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues and suicide and are less likely to have health insurance than straight or LGBT individuals.

Important note: Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Visit **glma.org** for more information about:

- Creating a welcoming environment.
- General guidelines (including referral resources).
- Confidentiality.
- Sensitivity training.

Visit **glaad.org** for additional resources on how to fairly and accurately report on transgender people.

Additional resources to help you support the needs of your LGBT patients:

- Providing Enhanced LGBT Courses — Cultural Competency Training **https://www.hhs.gov/programs/topic-sites/lgbt/enhanced-resources/competency-training/index.html**
- Creating an LGBT Friendly Practice **https://mydiversepatients.com/le-lgbt.html**
- LGBT Training Curricula for Behavioral Health and Primary Care Practitioners **https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula**

Pain management across cultures

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management. These tips are generalizations only. **It is important to remember that each patient should be treated as an individual.**

Reaction to pain and expression of pain

- Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain.
- Some men may not verbalize or express pain because they believe their masculinity will be questioned.
- Do not mistake lack of verbal or facial expression for lack of pain. Under treatment of pain is a problem in populations where stoicism is a cultural norm.
- Because the expression of pain varies, ask patients what level or how much pain relief they think they need.
- Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.

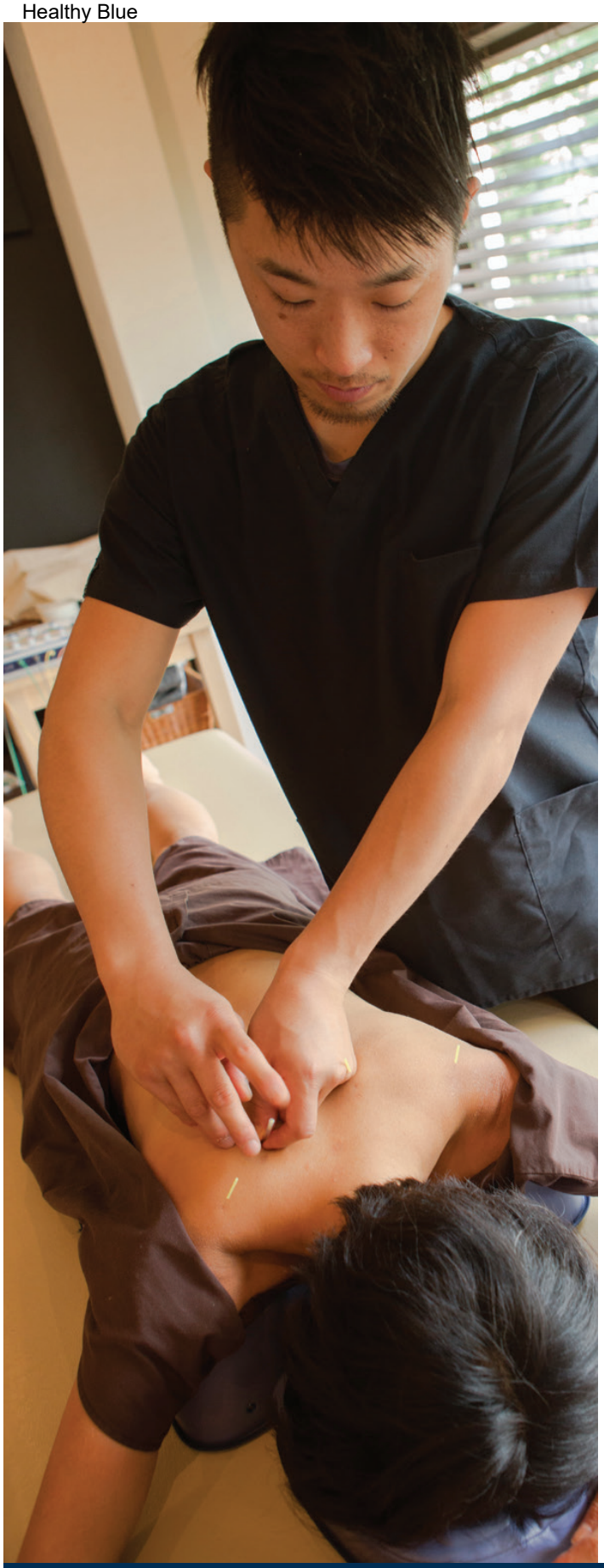
Do not mistake lack of verbal or facial expression for lack of pain. Under treatment of pain is a problem in populations where stoicism is a cultural norm.

Spiritual and religious beliefs about using pain medication

- Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief.
- Other religious traditions forbid the use of narcotics.
- Spiritual or religious traditions may affect a patient's preference for the form of medication delivery: oral, intravenous or intramuscular.
- Consultation with the family and spiritual counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices.
- Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment.
- Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.

Beliefs about drug addiction

- Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population.
- Past negative experience with pain medication shapes current community beliefs, even if the medications and doses have changed.
- Be aware of potential differences in the way medication acts in different populations. A patient's belief that he or she is more easily addicted may have a basis in fact.
- Explain how the determination of type and amount of medication is made. Explain changes from past practices.
- Assure your patient you are watching his or her particular case.



Use of alternative pain relief treatment

- Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture, or breathing exercises.
- Respectfully inquire about all of the ways the patient is treating his or her pain.
- Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until he or she feels it is *safe* to talk about them.
- Accommodate or integrate your treatments with alternative treatments when possible.

Accommodate or integrate your treatments with alternative treatments when possible.

Methods needed to assess pain

- Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.
- Ask the patient specifically how he or she can best describe his or her pain.
- Use multiple methods of assessing pain, such as scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results.
- Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques.
- Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as *like a burn from a stove*, *cutting with a knife or stepping on a stone*, may produce a more accurate description.

Regulations and standards for cultural and linguistic services

45 CFR 92, Nondiscrimination Rule

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement: A covered entity shall take reasonable steps to provide meaningful access to each individual with LEP eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance: In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the director shall: (1) evaluate and give substantial weight to the nature and importance of the health program or activity, and the particular communication at issue, to the individual with LEP; and (2) take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements: Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely and protect the privacy and independence of the individual with LEP. (d) Specific requirements for interpreter and translation services: Subject to paragraph (a) of this section: (1) a covered entity shall offer a qualified interpreter to an individual with LEP when oral interpretation is a reasonable step to provide meaningful access for that individual with LEP; and (2) a covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication. A covered entity shall not: (1) require an individual with LEP to provide his or her own interpreter; (2) rely on an adult accompanying an individual with LEP to interpret or facilitate communication, except: (i) in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) where the individual with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances; (3) rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with LEP immediately available; or (4) rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.

(f) Video remote interpreting services: A covered entity that provides a qualified interpreter for an individual with LEP through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry or grainy images, or irregular pauses in communication; (2) a sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) a clear, audible transmission of voices; and (4) adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with LEP to accept language assistance service.

Standards to provide culturally and linguistically appropriate services (CLAS)

The purpose of the enhanced OMH National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 standards are necessary to advance health equity, improve quality and help eliminate health care disparities.

Principal standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, leadership and workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and language assistance

5. Offer language assistance to individuals who have LEP and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement and accountability

9. Establish culturally and linguistically appropriate goals, policies and management accountability and infuse them throughout the organizations' planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Title VI of the *Civil Rights Act of 1964*

Under *Title VI*, any agency, program or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring *meaningful access* to health care and equal care for all patients. Other federal and state legislation protecting the right to equal care outline how this principle will be operationalized.

State and federal courts have been interpreting *Title VI*, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the OMH have become more active in interpreting and enforcing *Title VI*.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued *Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency.* This policy established national origin as applying to limited English speaking recipients of federally funded programs.

> "No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Executive Order 13166: improving access to services for persons with limited English proficiency (August 2000, verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section one: goals

The federal government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The federal government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each federal agency shall also work to ensure that recipients of federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Section two: federally conducted programs and activities

Each federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Section three: federally assisted programs and activities

Each agency providing federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order. The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Section four: consultations

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Section five: judicial review

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON, THE WHITE HOUSE
Office of the Press Secretary
(Aboard Air Force One) For Immediate Release August 11, 2000
Reference: **www.justice.gov/crt/executive-order-13166**

Race/ethnicity/language categories

Importance of collecting race/ethnicity/language (REL) data and appropriate use

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.

The health plans collect this data and can make this data available to providers on request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) ethnicity categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field *Unknown, Unable to Complete* or *Other*.

OMB race categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American: A person having origins in any of the Black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories.
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete. May call this field *Unknown*.

Resources for cultural and linguistic services

Cultural competence web resources

General cultural competence	
U.S. Department of Health and Human Services — Think Cultural Health	**https://www.thinkculturalhealth.hhs.gov**
U.S. Department of Health and Human Services — OMH	**http://www.minorityhealth.hhs.gov**
National Institute of Health	**https://www.nih.gov**
HHS Health Resources and Services Administration Culture, Language and Health Literacy	**https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy**
U.S. Department of Justice — Civil Rights Division	**https://www.justice.gov/crt**
HHS Office of Civil Rights	**www.hhs.gov/ocr**
Industry Collaboration Effort	**http://iceforhealth.org/aboutice.asp**
National Center for Cultural Competence — Georgetown University	**https://nccc.georgetown.edu/**
Office of Disease Prevention and Health Promotion Quick Guide to Health Literacy	**https://health.gov/our-work/health-literacy**
My Diverse Patients	**https://www.mydiversepatients.com**
National Council on Interpreting in Health Care	**www.ncihc.org**
Resources for cross-cultural health care	**www.diversityrx.org**
Institute of Medicine: Unequal Treatment	**http://iom.nationalacademies.org/reports/2002/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.aspx**
Robert Woods Johnson Foundation: Aligning Forces for Quality	**www.rwjf.org/en/library/collections/af4q.html**
National Partnership for Action to End Health Disparities	**https://minorityhealth.hhs.gov/npa**
Limited English Proficiency: A Federal Interagency Website	**https://www.lep.gov**

Aging	
Center on an Aging Society	**http://hpi.georgetown.edu/agingsociety**

African American	
National Association of Black Cardiologists	**www.abcardio.org**
National Black Nurses Association	**www.nbna.org**

American Indian/Alaska Native	
Association of American Indian Physicians	**www.aaip.org**
Native American Cancer Research	**http://natamcancer.org**
National Indian Council on Aging	**http://nicoa.org**
National Indian Health Board	**www.nihb.org**
National Resource Center on Native American Aging	**https://ruralhealth.und.edu/projects/nrcnaa**

Asian American/Pacific Islander American	
Asian & Pacific Islander American Health Forum	**www.apiahf.org**
Chinese American Medical Society	**www.camsociety.org**
National Asian Pacific Center on Aging	**http://napca.org**

Hispanic/Latino American	
National Alliance for Hispanic Health	**https://www.healthyamericas.org**
National Hispanic Council on Aging	**www.nhcoa.org**
National Hispanic Medical Association	**www.nhmamd.org**

Disabilities	
U.S. Department of Justice — *ADA* Requirements for Effective Communication	**https://www.ada.gov/effective-comm.htm**
Administration for Community Living DHHS	**https://www.acl.gov/about-community-living**

Free patient health education materials — low literacy and other languages	
National Institutes of Health — health information in English/Spanish	**www.health.nih.gov**
National Network of Libraries of Medicine — easy-to-read health brochures in other languages	**http://nnlm.gov/outreach/consumer/multi.html**

Remember, webpages can expire. If the web address provided does not work, use a search engine and search under the organization's name.

This information is intended for educational purposes only and should not be interpreted as medical advice. Please consult your provider for advice about changes that may affect your health.

Linkage to the websites listed is for educational purposes only and is not intended as a particular endorsement of any organization.

If you have any questions or comments about this toolkit, please contact your provider representative.

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* Ask Me 3 is an independent company providing patient education services on behalf of Healthy Blue. 211 is an independent company providing community services on behalf of Healthy Blue. 711 is an independent company providing community services on behalf of Healthy Blue.

Notes

https://provider.healthybluene.com

BNEPEC-0245-20

Healthy Blue | HERITAGE HEALTH

New provider orientation

Agenda

- About us
- Eligibility and benefits
- Claims tools and resources
- Compliance
- Quality management
- Partner services
- Provider resources
- Joining our network

About us

Introducing Healthy Blue

In January 2020, Anthem, Inc. purchased the WellCare of Nebraska, Inc. health plan. Our program is now called Healthy Blue. Healthy Blue is proud to serve our Nebraska members.

Your local Provider Relations staff will serve our provider network across the state.

Current offices include Omaha, Norfolk, Scottsbluff, Kearney, and Lincoln.

☆ Corporate Office

★ Welcome Room

Purpose, vision and values

Our mission

Improving lives and communities.
Simplifying health care.
Expecting more.

Our vision

To be the most innovative, valuable and inclusive partner

Our values

Leadership
Community
Integrity
Agility
Diversity


Member eligibility and benefits

Verifying member eligibility

Eligibility and benefits associated with a member and/or their dependents can be determined two ways:

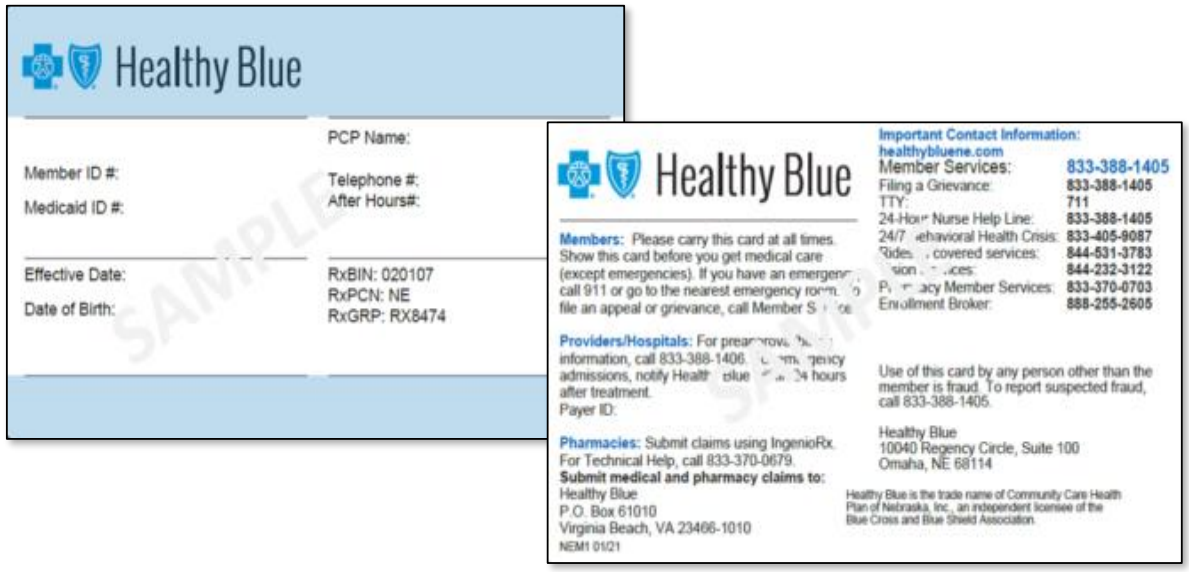
- Submitting a 270/271 electronic data interchange (EDI) transaction using your EDI software or through your clearinghouse.
- Submitting an eligibility and benefits inquiry through the Availity Portal.*
  - The secure Availity Portal is your exclusive, secure multipayer portal to access many Healthy Blue online tools and resources.
- Go to https://www.availity.com Select Patient Registration > Eligibility and Benefits. Select **Healthy Blue** from the drop-down box.
- Complete required fields and submit.
  - When checking eligibility for 599 CHIP Unborn population the gender field will need to remain blank.

Verifying member eligibility (cont.)

You will continue to be able to verify member eligibility information through the state.

- Nebraska Medicaid eligibility system interactive voice response — Telephone voice response system:
  - Log in and password request: **1-800-967-7902**
  - Eligibility verification phone number: **1-800-642-6092**
- Web access to direct eligibility verification via MMIS at http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx.

Sample member ID cards



Required covered benefits and services

- Healthy Blue will cover, at a minimum, all benefits and services deemed medically necessary that are covered under our contract with the Department of Health and Human Services.
- While some Healthy Blue members have copays for certain services, there are certain exceptions. A complete listing of covered benefits and copays can be found in our provider manual.

For more information on covered benefits, refer to the **Healthy Blue Provider Manual.**

There are no copays for:

- Members who are 18 years of age or younger.
- Pregnant members, during pregnancy and through postpartum — the last day of the month following the 60-day postpartum period.
- Members who are in an institution and whose services are reduced because of personal income.
- Members receiving hospice care.
- American Indian members.
- Members who are receiving Medicaid for treatment of breast or cervical cancer.

Behavioral health services

Healthy Blue will continue providing members with a comprehensive array of mental health and substance abuse services for adults, adolescents and children including:

- Behavioral health inpatient services.
- Standard outpatient services.
- Residential treatment.
- Halfway house services.
- Community based services
- Peer support services.
- Psychological testing (requires prior authorization)
- Members can self-refer and do not need to call their PCP for a referral for a mental health or substance abuse assessment.
- Emergency behavioral health services do not require authorization.
- Inpatient admission notification is required on the next business day following admission.
- For some outpatient services, members can schedule appointments and access services with no prior authorization from Healthy Blue required.

For more information on Behavioral health benefits,
refer to the Provider Manual.

Pharmacy services

To ensure members receive the most out of their pharmacy benefit, consider the following guidelines when writing prescriptions:

- Follow national standards of care guidelines for treating conditions.
- Prescribe preferred drugs (see provider website for link to covered drugs).
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class.
- Evaluate medication profiles for appropriateness and duplication of therapy.

Review the new Healthy Blue pharmaceutical utilization management (UM) tools that are used to optimize the pharmacy program and they include:

- PDLs
- Medication prior authorization process
- Mandatory Generic Policy
- Step therapy (ST)
- Quality Level Limit (QL)
- Restrictive services

For more information on pharmaceutical utilization management (UM) tools, refer to the Provider Manual and https://provider.healthybluene.com.

Maternal Child Services — The New Baby, New Life Program

- Healthy Blue offers the New Baby, New Life$_{SM}$ Program. For newly-identified pregnant women, complete the *Maternity Notification Form* and fax it to **1-800-964-3627**.
- For pregnant women that have delivered, complete the *Newborn Notification of Delivery Form* and fax it to **1-800-964-3627**.
- Or complete these forms using the Interactive Care Reviewer (ICR) platform.
- Care management is available for those members with high risk pregnancies.

As part of the New Baby, New Life program, members may receive the My Advocate®* program as well.

This program provides pregnant and postpartum women proactive, culturally appropriate outreach and education though interactive voice response (IVR), web or smartphone application.

For more information on My Advocate, visit www.myadvocatehelps.com.

Disease Management program

Healthy Blue offers a Disease Management program that is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions.

- Asthma
- Bipolar disorder
- Diabetes
- Chronic Obstructive Pulmonary Disorder (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- HIV/AIDS
- Hypertension
- Major Depressive Disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder (SUD)
- Weight management and education

Disease Management can be reached **1-888-830-4300**
Monday to Friday 8 a.m. to 6 p.m. CT.

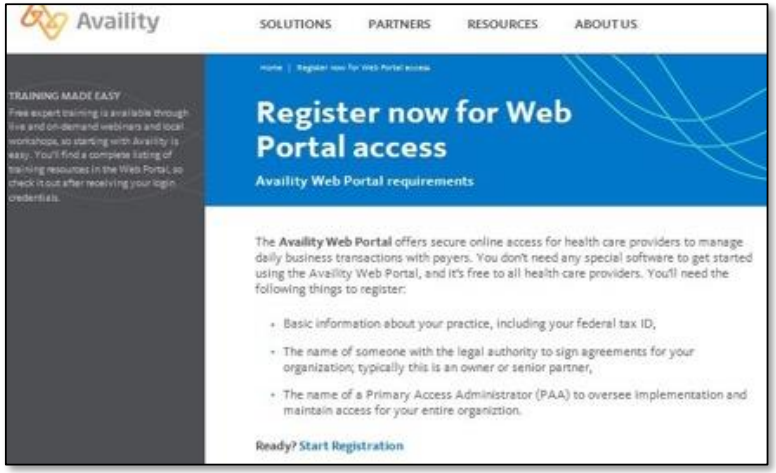

Tools and resources

Availity Portal

Your organization must be registered on the Availity Portal, and you need a unique ID and password.

To register:

- Visit https://www.availity.com and select **Register**.
- To access Availity training, login to Availity.
- Click **Help & Training | Get Trained**.
- If you are new to Availity, you will need to name an administrator who can grant you access to the tools you need.
- If you already use Availity, no additional registration is needed. Healthy Blue will appear as one of your options in the payer drop-down.



Public website

Provider online reporting registration

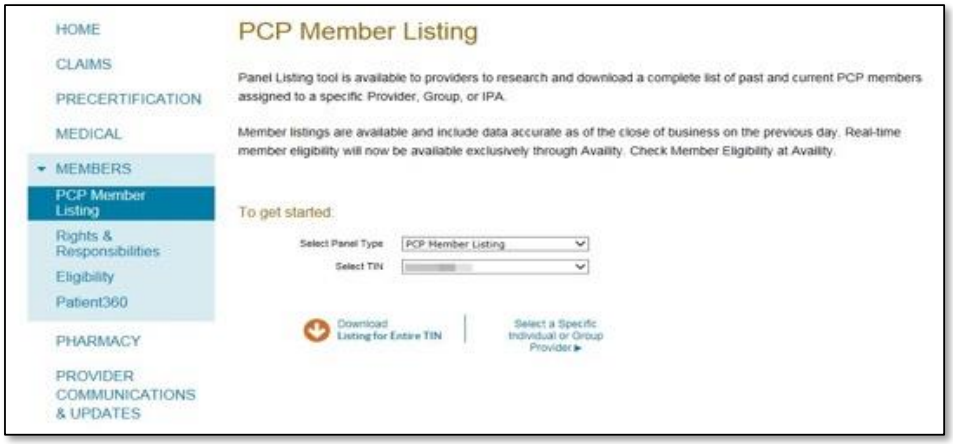
The provider organization's Availity administrator is responsible for registering the tax IDs and users for provider online reporting.

The administrator will take the following steps to register:

- From the *Availity* homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select **Applications**, then select **Provider Online Reporting**.
- Select **Register/Maintain Organization** to register your organization's tax ID to the applicable program. Select **Register Tax ID** to register for the eligible program (member reports or panel listings).
- Select **Maintain User/Register User** to grant access to users. (Users also must be given the Provider Online Reporting role assignment on the Availity Portal)
- Complete all fields on the *Register User* page. Select **ADD TO PREVIEW** and **Save**.

Provider Panel Listing Tool

- The Provider Panel Listing Tool is a tool for providers to research and download a complete list of past and current members assigned to a specific provider, group or independent practice association.
- Member listings include data captured at the close of business on the previous day.
- Real-time member eligibility is available through the Availity Portal.
- Member panel listings and reports are accessible via the provider online reporting application under *Payer Spaces*.
- Registration for provider online reporting is required.



Healthy Blue provider website and Availity Portal comparison

Available through the Healthy Blue provider website:
https://provider.healthybluene.com

- 24/7 access to all providers, regardless of participation status
- Open access without registration/login
- Claims forms
- Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool
- Provider manual
- *Clinical Practice Guidelines*
- News and announcements
- *Provider Directory*
- Fraud, waste and abuse resources
- *Preferred Drug Lists* (*PDLs*)
- *Medical Policies*

Available through the Availity Portal:
https://www.availity.com

- Registration/login required for access
- 24/7 access
- Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool
- Patient360 (provider facing)
- Multiple eligibility and benefits inquiry
- POR — Provider Online Reporting
- PCP member panel listings
- Interactive Care Reviewer (ICR) — medical prior authorizations requests
- Pharmacy authorizations and benefits
- Claims dispute submission and inquiry
- Medical appeal prior authorization submission
- *Availity EDI Guide*
- Maternity identification
- *HEDIS® Attestation*
- Remittance Inquiry


Claims and encounters

Clean claims

A clean claim is a claim submitted for reimbursement that contains the required data elements and any attachments requested by Healthy Blue.

To qualify as a clean claim, we require the following attachments:

- A Medicare remittance notice if the claim involves Medicare as a primary payer and Healthy Blue provides evidence it does not have a crossover agreement to accept an electronic remittance notice.
- Description of the procedure or service, which may include the medical record if a procedure or service rendered has no corresponding CPT® or HCPCS code.
- Documents referenced as contractual requirements in a global contract (if applicable).
- Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute.

Find more information on the required data elements and attachments
in the Healthy Blue provider manual.

Claims submissions

Claims submission timeframes.

- Claims must be submitted within 180 days of the date of service and 365 days of the date of service, where Healthy Blue is the secondary payer.
- Claims will be processed and paid or denied within 15 business days of receipt.
- Daily check runs for both paper checks and electronic funds transfer (EFT) payments, except for Sundays and the last day of each month.

Healthy Blue encourages the submission of claims electronically through the Electronic Data Interchange (EDI).

Using our electronic tool reduces claims/payment processing expenses and offers:

- Faster processing than paper.
- Enhanced claims tracking.
- Real-time submissions directly to our payment system.
- *HIPAA*-compliant submissions.
- Reduced claim rejections and adjudication turnaround time.

Claims submissions (cont.)

Electronically: Electronic claims submission can be done either by using a clearinghouse or sending directly. Availity serves as our gateway for all EDI transactions.

- If you have a relationship with a clearinghouse, please work with them to ensure connectivity with Availity.
- Healthy Blue Payer ID number is 00544.
- Providers can also register with Availity at http://www.availity.com to become a direct submitter.
  - To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**).
  - Availity Client Services is available Monday to Friday 9 a.m. to 8 p.m. CT.

Fax: We do not accept faxed claims — 365 days is the timely filing limit when Healthy Blue is the secondary payer.

Paper Claims address: Healthy Blue, PO Box 61010, Virginia Beach, VA 23466-1010

Claim status inquiries

You can obtain claim status information through the Availity Portal or by calling Healthy Blue Provider Services.

To access the information on Availity Portal:

- Perform a claim status inquiry: At the top of Availity Portal, select **Claims & Payments | Claim Status** In the *Organization* field, select the organization and in the *Payer* field, select Healthy Blue.
- You must be assigned the claim status role to access the claim status application.
- Tip: Start from an eligibility and benefits response (patient card) and select the **Go To** button located in the top right-hand of the inquiry, and then select **Check Claim Status**.
- For more claims training, select **Help & Training**, then **Get Trained** and search for Claim Status Inquiry – Training Demo.

Rejected versus denied claims

There are two types of notices you may get in response to your claim submission, rejected or denied.

Rejected claims	**Denied claims**
do not enter the adjudication system because they have missing or incorrect information.	go through the adjudication process but are denied for payment.

- You can find claims status information on the Healthy Blue provider website at https://provider.healthybluene.com or by calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.
- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment* (*EOP*), letter of explanation and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

Claims overpayment recovery and refund procedure

- Healthy Blue seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable and initiates the overpayment recovery process by sending written notification.
- If you are notified of an overpayment or discover that you have been overpaid, mail the refund check along with a copy of the notification or other supporting documentation the address below.
- The *Recoupment Notification Form* and *Overpayment Refund Notification Form* are located at https://provider.healthybluene.com.
- For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 30 days, the overpayment amount is deducted from your future claims payments.
- If you believe the overpayment notification was created in error, contact Healthy Blue Provider Services **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Healthy Blue
P.O. Box 61599
Virginia Beach, VA 23466-1599

Provider claim payment disputes

- If a provider disagrees with the outcome of a claim, you may begin the claim payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome. We must receive your dispute within **90** calendar days from the date of the *EOP*.
- The claim payment dispute process consists of two steps. Providers will not be penalized for filing a claim payment dispute, and no action is required by the member.

Claim payment reconsideration:
This is the first step in the claim payment dispute process. The reconsideration represents the initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

Claim payment appeal:
This is the second step in the claim payment dispute process. If a provider disagrees with the outcome of the reconsideration, the provider may request an additional review as a claim payment appeal.

Submitting claim payment disputes

How to submit a provider dispute

There are several options for filing a dispute:

Online:

Use the secure Provider Availity Payment Dispute Tool at https://www.availity.com

Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.

Verbally (reconsiderations only):

Call Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Written (reconsiderations and claim payment appeals):

Reconsideration Form is located a https://provider.healthybluene.com

Mail all required documentation to:
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

Provider claim payment disputes

Claim payment disputes do not include:

- **Medical necessity/authorization denials**
  A claim may deny for a *denied authorization*, *not medically necessary* or something similar. In these instances, the claim payment was denied due to a denial of the authorization/service. These should be managed through the grievance and appeals process.
- **No authorization denials**
  When a service requires an authorization, but authorization was not requested, a claim will deny for *no authorization*. If you would like to have the service considered, submit the medical record for review through the correspondence process.

Claim correspondence

- Correspondence is when Healthy Blue requests more information to finalize a claim.
- Correspondence is **not** considered a provider claim payment dispute.
- Typically, request for information is done through the *EOP*.
  - Examples: Submit medical record, submit itemized bill, submit other health information.
- The claim or part of the claim will appear as denied on the *EOP*.
  - However, this is only because more information is required to finalize the claim.
  - Once the information is received, Healthy Blue will use it to finalize the claim.

You may submit correspondence:

- **Online** — This is the most efficient way to submit correspondence. You can submit through Availity. You can access the online tool at https://www.availity.com.
- **In writing** – Mail all required documents to:
  Healthy Blue
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Reimbursement Policies

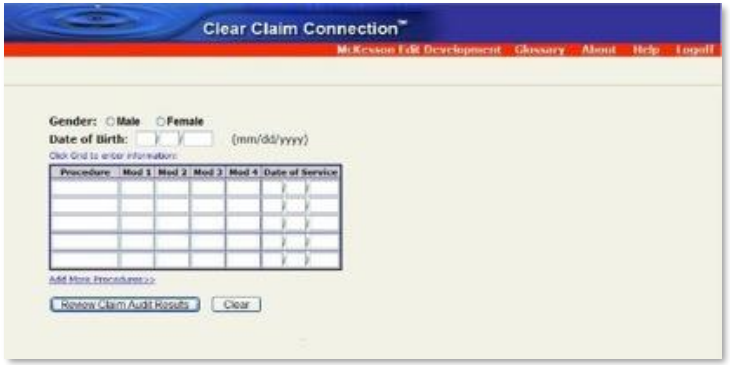
- *Reimbursement Policies* serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan.
- Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard compliant codes on all claim submissions.
- The billed code(s) should be fully supported in the medical record and/or office notes.

Reimbursement Policies are located on the Healthy Blue provider website https://provider.healthybluene.com and the Availity Portal https://www.availity.com.

Clear Claim Connection

Use Clear Claim Connection™ for guidance when you submit a claim.

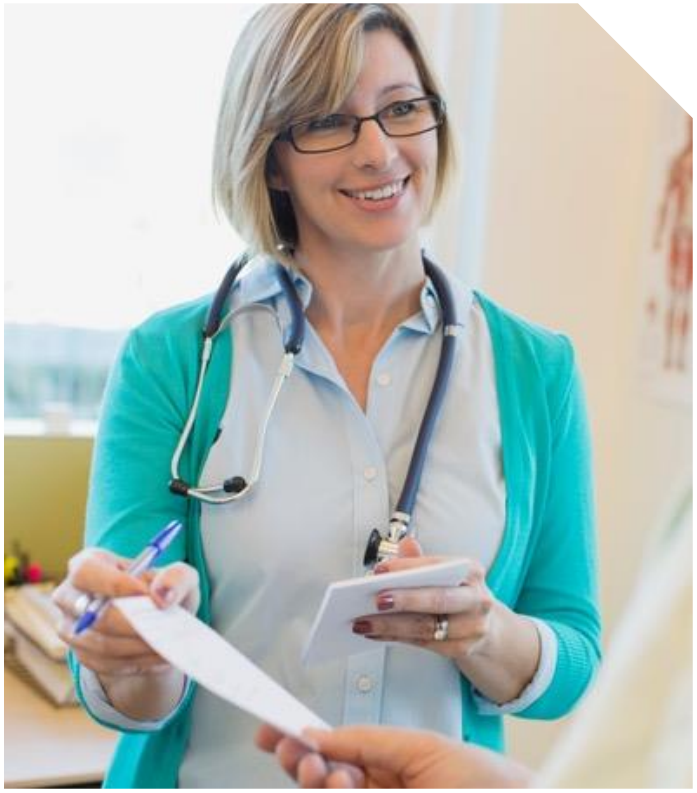
- The tool is available on the Availity Portal through Payer Spaces, and can help you determine whether procedure codes and modifiers will likely pay for your patient's diagnosis.
- It contains editing features that will determine the validity of items like diagnosis codes or revenue codes. If the codes are not valid, it will produce an edit showing such.



Code and clinical editing

- Healthy Blue applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits.
- Healthy Blue uses sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices.
- Editing sources include but are not limited to CMS National Correct Coding Initiative, *Medical Policies* and *Clinical Utilization Management Guidelines*.
- We are committed to working with you to ensure timely processing and payment of claims.
- For additional information, refer to the provider manual and/or your *Provider Agreement* as a guide for reimbursement criteria. You can also contact Healthy Blue Provider Services Monday to Friday 8 a.m. to 9 p.m. CT. for more information.

Electronic payment services



Enrolling in electronic funds transfer (EFT) provides the following benefits:

- Claims payments are deposited to your account faster.
- EFT payments don’t get delayed or lost in the mail.
- EFT payments are more protected from fraud.
- You save time with fewer trips to the bank.
- You save money by reducing your associated labor and case security costs.

Registering for electronic remittance advice (ERA) providers the following benefits:

- You can easily access your remittance advice online.
- Transactions can be posted to your system automatically.

Electronic payment services (cont.)

- In order to receive EFT payments you will need to register and enroll with the CAQH© Solutions EnrollHub™ tool at https://www.caqh.org/solutions/enrollhub and select the payer name containing Healthy Blue.
- For registration-related questions, contact EnrollHub Help Desk at **1-844-815-9763** Monday to Thursday 8 a.m. to 10 p.m. CT. Friday 8 a.m. to 8 p.m. CT. or efthelp@EnrollHub.CAQH.org.
- Even if you are registered with CAQH and enrolled with another payer, you will need to enroll in Healthy Blue to receive payments via EFT.

For even more convenience, you can also enroll for online Electronic Remittance Advice (ERA):

- If you wish to enroll for ERA (835), use Availity to register and manage account changes.
- If you have a relationship with a clearinghouse, (Please work with them to ensure connectivity to the Availity EDI Gateway.)
- Visit https://apps.availity.com/web/welcome/#/edi to get started. If you have any questions, contact Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** Monday to Friday 8 a.m. to 7:30 p.m. CT.

Remittance inquiry

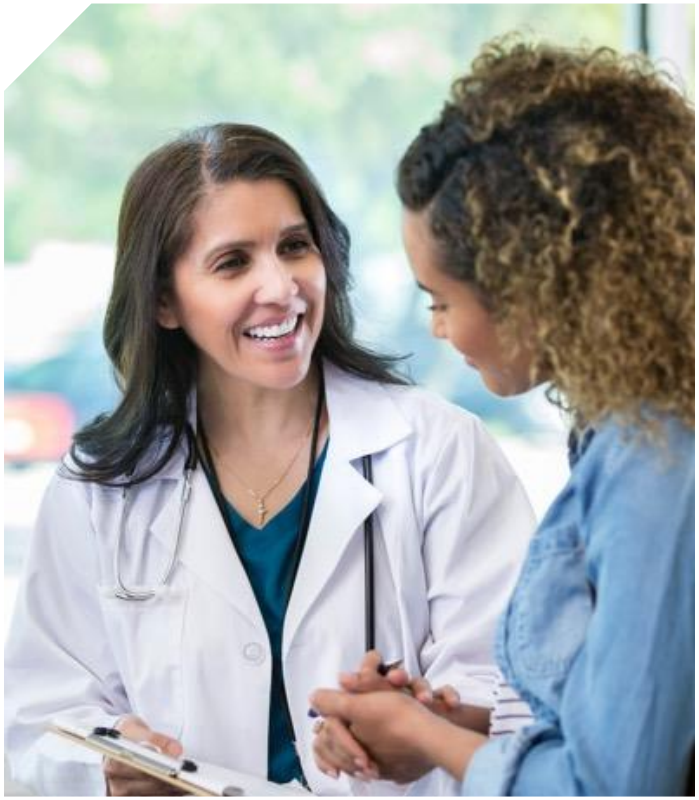
- You will be able to view/receive remittance information through the Availity Portal.
- From the Availity Portal homepage Select Payer Spaces > Healthy Blue NE > Applications. The *Remittance Inquiry* application will appear as an option. Choose *Remittance Inquiry* to gain access to the *Remittance Inquiry* functionality.
- Choose your organization and tax ID number. If the administrator previously loaded NPIs, select your NPI from the *Express Entry* drop-down menu. Otherwise, enter an NPI number in the allotted box.
- You can choose from one of three search options:
  - EFT number
  - Check number
  - Date range
- If you need an image of the remittance for your files, select the **View Remittance** link associated with each remit on the list and **Print** or **Save**.
- Contact your administrator if you do not see this tool to request claims status access. If you don’t know who the administrator is for your organization, log in to Availity and select **My Administrators**.

Encounter data

- Services provided to Healthy Blue members by our providers are required to be reported to state and federal entities as encounters.
- Encounters are used by government entities for quality assessments and rate calculations.

The Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care (MLTC) collects and uses this data for many purposes such as:

- Federal reporting.
- Rate setting.
- Risk adjustment.
- Service verification.
- Managed care quality improvement.
- Utilization patterns.
- Access to care determinations.
- Various research studies.




Utilization management and prior authorizations

Inpatient concurrent review

- Inpatient concurrent review is the process of obtaining clinical information to establish medical necessity for a continued inpatient stay including review for extending a previously approved admission. Failure to submit clinical information may results in a lack of information adverse determination (denial).
- Facilities are required to supply the requested clinical information within 24 hours of the request to support continued stay.
- During each concurrent review interval, the clinician will assess member progress and needs to help coordinate such needs prior to discharge. This is done to help facilitate a smooth transition for the member between levels of care or home and to avoid delays in discharge due to unanticipated care needs.
- In addition, the attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

Inpatient level of care review guidelines

- MCG Care Guidelines are evidence-based guidelines used for clinical decisions and care planning. There are separate guidelines covering specific areas of care. MCG Care Guidelines for inpatient level of care will be used on go-live.
- Healthy Blue has the right to customize MCG Care Guidelines based on determinations by Its Medical Policy and Technology Assessment committee.

Precertification Lookup Tool

- Certain medical procedures require the submission and approval of PA.
- To verify if PA is required, use the Precertification Lookup Tool.

Detailed authorization requirements can be found using the Precertification Lookup Tool:

- Search by market, member product and CPT code.
- This is for outpatient services only — All inpatient services require an authorization.

Precertification Lookup Tool is located under *Payer Spaces* on the Availity Portal:

- From the Availity Portal homepage, select **Payer Spaces** from the top navigation bar.
- Select the health plan.
- From the *Payer Spaces* homepage, select the **Applications** tab.
- Select **Precertification Lookup Tool**.

Prior authorization and notification

You can submit a PA request, look up a status or submit a clinical appeal online using our self service authorization tool – Interactive Care Reviewer.

- Log in to https://www.availity.com using your Availity. Then:
- From the Availity Portal homepage, select **Patient Registration** from the top navigation bar.
- Select **Authorizations & Referrals**.
- Select **Authorizations**.
- Select the payer and organization.
- Select **Submit**.
  - The Interactive Care Reviewer (ICR) application will open.
  - Use ICR to submit and manage (appeal) your medical PAs.
  - Urgent request can be submitted via ICR or by calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

AIM Specialty Health

- AIM Specialty Health®* manages precertification for the following modalities: Radiology, Cardiology, Sleep, Musculoskeletal, Rehabilitation (PT, OT, ST), Genetic Testing and Radiation Oncology.
- **How to place a review request:**
  - **Online** — via the AIM Provider Portal. Provider Portal is available 24/7, and processes requests in real-time using clinical criteria. Go to www.providerportal.com to register.
  - **By phone** — Call AIM Specialty Health toll free at **1-855-574-6478** Monday to Friday 7 a.m. to 7 p.m. CT.
- For resources to help your practice get started with AIM specialty benefits program, visit www.providerportal.com to learn more and gain access to useful information and tools such as order entry checklists, Clinical Guidelines and FAQs.

PA for inpatient admissions

- All medical emergent inpatient hospital admissions will be reviewed within 72 hours or three calendar days of the facility notification to Health Blue.
- Emergent inpatient admissions require notification within one business day following the admission.
- Authorizations can be submitted via phone, fax or Availity Portal.
- Failure to comply with notification and authorization rules will result in an administrative denial.

Availity:
https://www.availity.com

Fax: Nonbehavioral health:
1-800-964-3627

Fax: BH:
- **Inpatient: 1-844-462-0024**
- **Outpatient: 1-844-462-0027**

Healthy Blue Provider Services:
1-833-388-1406
Monday to Friday 8 a.m. to 9 p.m. CT.

PA for inpatient admissions (cont.)

Elective admissions

- Healthy Blue requires precertification of all inpatient elective admissions. The referring primary care provider (PCP) or specialist physician is responsible for precertification.
- The referring physician identifies the need to schedule a hospital admission and must submit the request to the Healthy Blue Medical Management department.
- Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow us to verify benefits and process the precertification request.
- For services that require precertification, Healthy Blue makes case-by-case determinations that consider the individual's health care needs and medical history in conjunction with medical necessity criteria.

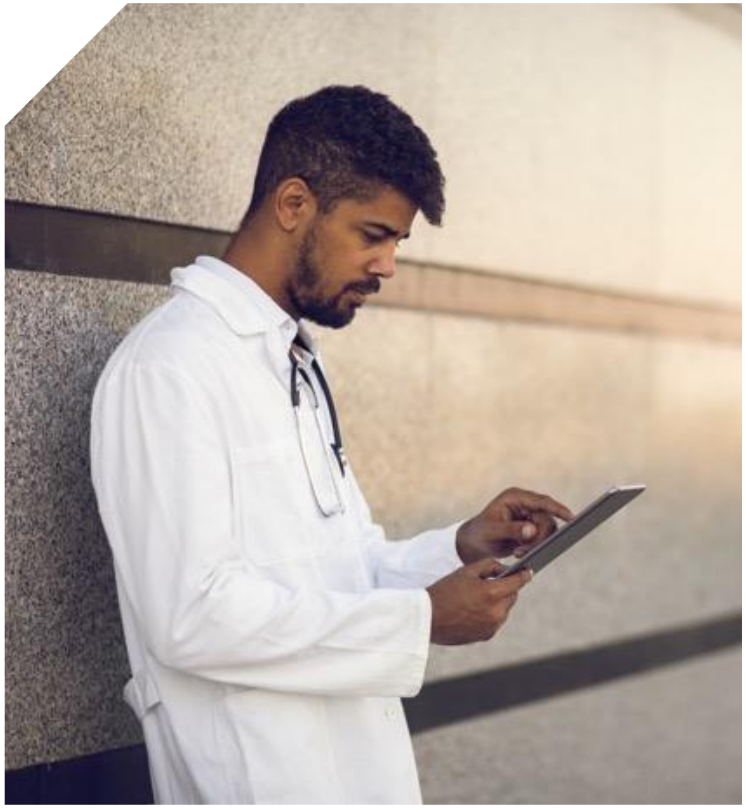
PA for inpatient admissions (cont.)

Emergent admissions

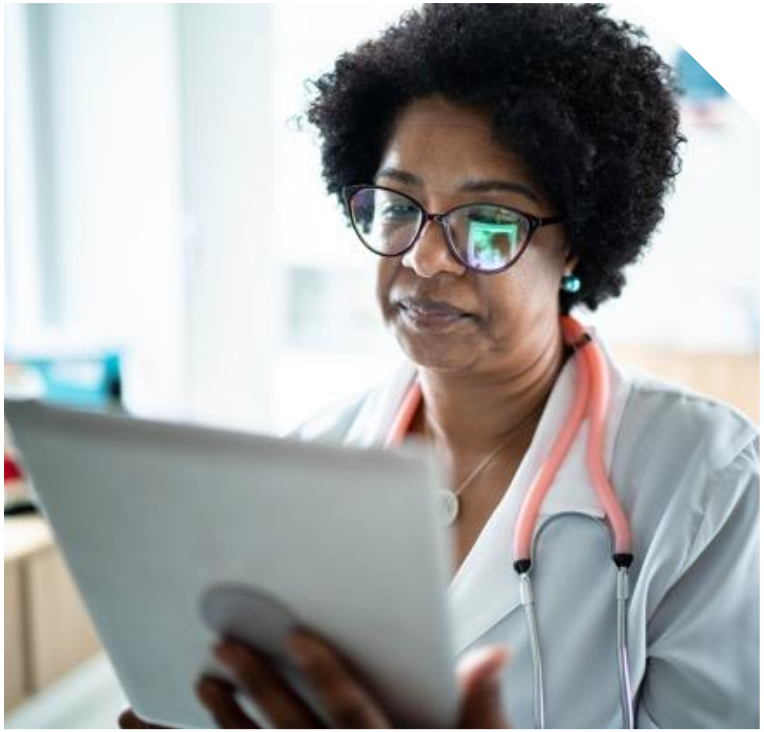
- We require immediate notification by network hospitals of emergent admissions. Network hospitals must notify us of emergent admissions within one business day.
- Healthy Blue Medical Management staff will verify eligibility and determine benefit coverage. No prior authorization is required for emergency admissions.

Observation stays

- For participating facilities, observation stay does not require notification or prior authorization.
- For nonparticipating facilities, authorization is required within one business day



PA for inpatient admissions (cont.)



- Clinical information for the initial (admission) review will be requested at the time of the admission notification.
- **If the information is not received within 24 hours, a secondary fax request will be sent.** If the clinical information is not received, then a lack of information adverse determination (denial) will be issued.
- If the clinical information **is received**, a medical necessity review will be conducted using applicable Nebraska *Clinical Coverage Policies*.
- Decisions are communicated verbally or via fax within 24 hours of the determination.

Grievances and appeals

Grievance:
A grievance is your expressed dissatisfaction about any matter except a payment dispute or a proposed adverse medical action. A grievance can be submitted either by a member or a physician, hospital, facility or other health care professional licensed to provide health care services.

Medical appeals:
There are separate and distinct appeal processes for our members and providers that depend on the services denied or terminated. Refer to the denial letter issued to determine the correct appeals process.

For grievances and appeals, contact Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Medical Polices and *Clinical Utilization Management Guidelines*

Clinical Coverage Polices are the primary guidelines and *Medical Policies* and *Clinical Utilization Management Guidelines* are the secondary guidelines used to determine whether services are considered to be:

- Investigational/experimental
- Medically necessary
- Cosmetic or reconstructive

A list of the specific *Medical Policies* and *Clinical Utilization Management Guidelines* will be posted and maintained on the Healthy Blue provider website and can be obtained in hard copy by written request.

To request a copy of the criteria on which a medical decision was based, call Healthy Blue Provider Services **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.


Compliance

Compliance program

- All providers, including provider employees and subcontractors, their employees and delegated entities, are required to comply with the Healthy Blue Compliance Program requirements, including those contracted with Healthy Blue.
- Requirements include, but are not limited to, the following:
  - Provider training requirements
  - Limitations on provider marketing
  - *HIPAA* Privacy and Security Training
  - Adherence to code of conduct and business ethics
  - Cultural competency and sensitivity
  - *Americans with Disabilities Act (ADA)* requirements
    - For more information on the *ADA* please visit http://www.ada.gov
    - To access interpreter and sign language services, please contact our Customer Service toll free line.
  - Fraud, Waste and Abuse (FWA) detection and prevention

For more information on program and specific compliance requirements,
refer to the *Healthy Blue Provider Manual*.

Cultural competency

Healthy Blue embraces the fundamental importance of cultural competency in reducing health disparities and improving access to high-quality health care.

- The purpose of the Cultural Competency program is to ensure that Healthy Blue meets the unique, diverse needs of all members, to provide that the associates of Healthy Blue value diversity within the organization and to see that members in need of linguistic services have adequate communication support.
- In addition, Healthy Blue is committed to ensuring that its staff and its provider partners, as well as its policies and infrastructure, are attuned to meeting the diverse needs of all members they serve.

The components of Healthy Blue's Cultural Competency Program include:

- Data analysis
- Diversity and language abilities of Healthy Blue's staff
- Linguistic services
- Provider education
- Community-based support
- Diversity of provider network
- Electronic media

Provider cultural competency resources

- Patient panels are growing more diverse and needs are becoming more complex; more support may be necessary to help address these needs.
- Healthy Blue offers support by ensuring resources are available to providers on the provider website. Resources include:
- **Cultural competency training (Cultural Competency and Patient Engagement)**, which includes but is not limited to:
  - The impact of culture and cultural competency on health care.
  - A cultural competency continuum which can help providers assess their level of cultural competency.
  - Disability sensitivity and awareness.

Provider cultural competency resources (cont.)

Caring for Diverse Populations Toolkit which includes but is not limited to:

- Comprehensive information, tools, and resources to support enhanced care for diverse patients and mitigate barriers.
- Materials that can be printed and made available for patients in provider offices.
- Regulations and standards for cultural and linguistic services.

My Diverse Patients

- Online resource offering comprehensive information to increase awareness of the needs of diverse patients, disparities that are present, and ways to enhance care and address those gaps.
- Includes courses offering **free** Continuing Medicaid Education (CME) credit through American Academy of Family Physicians (AAFP).
- Site access is free; no account or login required; site is accessible from any device (desktop computer, laptop, phone, tablet). These resources are available at https://provider.healthybluene.com.

Americans with Disabilities Act

- **The *Americans with Disabilities Act* (*ADA*)** became law in 1990. The *ADA* prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life.
- To be protected by the *ADA*, one must have a disability, which is defined by the *ADA* as a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The *ADA* does not specifically name all of the impairments that are covered.
- Participating Healthy Blue providers must:
  - Provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities.
  - Use waiting rooms and exam room furniture that meet the needs of all members, including those with physical and nonphysical disabilities.
  - Provide accessibility along public transportation routes and/or provide enough parking.
  - Use clear signage throughout the facilities (in other words, color and symbol signage).

Federal Fund Laws

Provider acknowledges that payments provider receives from Healthy Blue to provide Medicaid covered services to Medicaid members are, in whole or part, from federal funds. Therefore, provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, *Title VI* of the *Civil Rights Act of 1964* as implemented by 45 CFR Part 84; the *Age Discrimination Act of 1975* as implemented by 45 CFR Part 91; the *Americans with Disabilities Act*; the *Rehabilitation Act of 1973*, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, *Title IX* of the *Educational Amendments of 1972*, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

In accordance with section 6032 of the *Deficit Reduction Act of 2005* (*DRA*), provider shall, and shall require the other Providers to, comply with the Healthy Blue *Fraud and Abuse Prevention Policy*, as revised from time to time by Healthy Blue, and as otherwise may be required under the government contract.

Fraud, waste and abuse

CMS defines fraud, waste and abuse as:

Fraud

Intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit

Waste

Overusing services, or other practices that directly or indirectly result in unnecessary costs; generally not considered driven by intentional actions, but from misusing resources

Abuse

When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

Fraud, waste and abuse (cont.)

- If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it.
- No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting the Healthy Blue provider website and completing the *Report Waste, Fraud and Abuse* form.
- Calling Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.


Quality

Quality Improvement Program

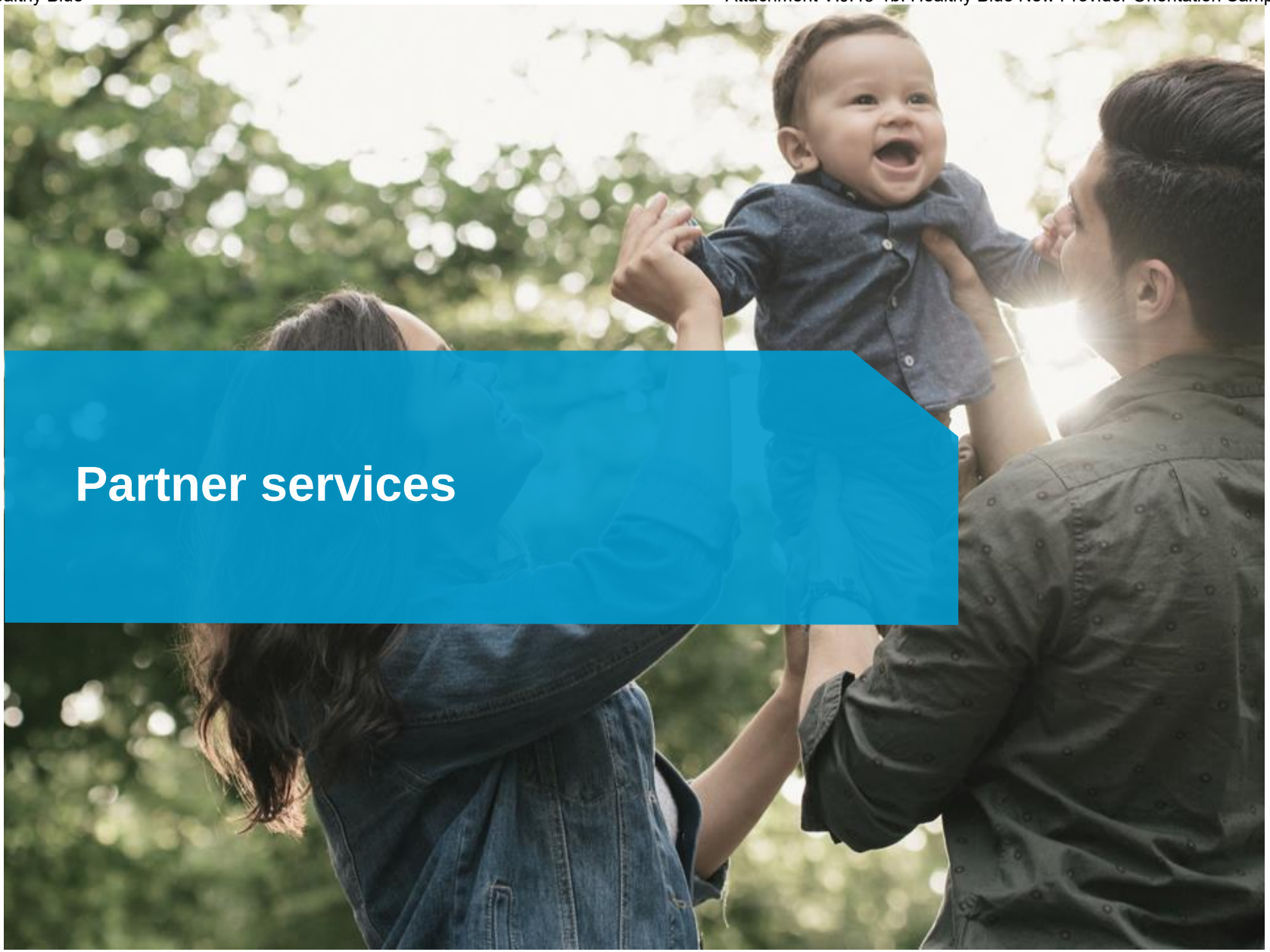
Healthy Blue Quality Improvement (QI) Program activities include, but are not limited to:

- Monitoring and improving clinical indicators and outcomes.
- Monitoring appropriateness of care.
- Quality studies.
- HEDIS measures.
- Medical records audits.
- Improving member and provider satisfaction.

Providers are contractually responsible for participating in QI projects and medical record review activities.

HEDIS is a mandatory process that occurs annually. It is an opportunity for Healthy Blue and its providers to demonstrate the quality and consistency of care that is available to members.

For more information on Healthy Blue Quality Improvement program, refer to the Healthy Blue website https://provider.healthybluene.


Partner services

Partner services

Healthy Blue to partners with IntelliRide* for transportation needs and Avesis* for vision needs.

Transportation:
IntelliRide

Trip reservations and ride assistance:
1-844-531-3783

Vision Services:
Avesis

Member and provider number:
1-844-232-3122


Provider resources

Your support system and staff

We support you through many different departments as you provide care to our members including:

- Our Healthy Blue Provider Relations team
- Our Healthy Blue Medical Management staff
- Specialized teams to help you with your claim questions
- Healthy Blue Provider Services

Call Healthy Blue Provider Services for assistance with claim issues, member enrollment and general inquiries at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.

Healthy Blue Provider Relations serves the following functions:

- Provider ongoing education and training
- Engaging providers in quality initiatives
- Building and maintaining the provider network
- Offering support for claims and billing questions and issues

You can always contact your local Healthy Blue Provider Relations representative with any questions you may have.

For more information

- Review the *Provider Manual* for more detailed information about provider requirements and how-to instructions, including:
  - Provider and member administrative guidelines
  - Claims
  - Credentialing
  - Utilization management and care and disease management
  - Quality improvement
  - Appeals and grievances
  - Delegated entities
  - Compliance
  - Pharmacy services
- Refer to the *Quick Reference Card* as your resources for the most common transactions with Healthy Blue, including:
- Registering for, and how to use Healthy Blue secure provider portal to review member eligibility and copay information, authorization requests, claims status and inquiry, provider news and more.
- How to file an electronic or paper claim.
- How to file a grievance.
- How to file an appeal.

Interpreter services

Use an interpreter, when necessary, to ensure your patient understands all his or her options and is able to make an informed decision.

Free interpreter services are available to Healthy Blue members, 24/7 with over 170 languages.

Call Healthy Blue Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT. (TTY number) for:

- Interpreter services for provider services.
- Telephonic interpreter services.
- In-person interpreter services for care management.

Access and availability

It's our responsibility to make sure our members have access to primary care services for:

- Routine care services.
- Urgent and emergency services.
- Specialty care services for chronic and complex care.

We make sure our providers respond to members' needs in a timely manner by conducting telephonic surveys to confirm providers are meeting these standards. Availability and access standards are specifically outlined in the provider manual.

Access and availability standards

PCPs must provide or arrange for coverage of services, consultation or approval for Referrals 24/7. Please refer to the provider manual for a complete list of access and availability standards.

Type of appointment	Access standard
PCP	
Urgent care	Same day
Sick care	≤ 72 hours
Preventive care	≤ 28 calendar days
Family planning	≤ 7 calendar days
Emergency medical need	Immediately
Office hours — 20	20 hours per week
Office hours — 30	30 hours per week
Wait time	≤ 45 minutes
Wait time update	≤ 90 minutes

After hours access standards

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP.
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes.
- An advice nurse with access to the PCP or on-call physician within 30 minutes.

Credentialing and provider updates

Credentialing process

- Healthy Blue follows the specific credentialing process set forth by NCQA.
- Once the CAQH application has been attested to and Healthy Blue has been given access, Healthy Blue's credentialing team will conduct primary source verification as appropriate and prepare the provider's file for review by the Credentials Committee.
- *Clean* credentialing files are reviewed daily by our Medical Director and approved accordingly. We are contractually obligated to complete processing of all clean credentialing applications within 30 days.
- Chaired by our Medical Director, the Credentials Committee meets monthly to review files based on the Credentialing criteria.
- Healthy Blue recredentials every three years and providers are asked to keep their CAQH applications current and available.

Provider changes

- Provider demographic changes should be submitted to Healthy Blue via email at NEProviderOperations@healthybluene.com or contact Provider Services at **1-833-388-1406** Monday to Friday 8 a.m. to 9 p.m. CT.
- To ensure our members and Care Management staff have up-to-date information, please submit demographic updates 30 days and terminations 90 days prior to the effective date.
  - Group name or affiliation
  - Telephone or fax number
  - Panel status
  - Tax identification number
  - Physical or billing address
  - Age limitation
  - 1099 mailing address
  - New NPI number
  - Office hours
  - Terminations
  - Hospital affiliations
  - Language spoken

* Demographic updates also need to be made with Maximus, the state Provider Enrollment system.

Key takeaways

Key items to prepare you for doing business with Healthy Blue:

- Sign up for the secure provider website. You can register with Availity and access training (https://www.availity.com)
- Use Availity to register for ERA (835); Payer ID 00544
- Register for electronic funds transfer (EFT) payments with CAQH EnrollHub
- Review the Healthy Blue provider website communications and other tools at https://provider.healthybluene
- Review your handouts
- Provider Service number and email address:
  - Provider Service: **1-833-388-1406** Monday to Friday 7 a.m. to 8 p.m. CT
  - Provider Relations: ProviderRelations_NE@healthybluene.com

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* AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue.
* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.
* Change Healthcare is an independent company managing the My Advocate program on behalf of Healthy Blue.
* Avesis is an independent company providing vision services on behalf of Healthy Blue.
* IntelliRide is an independent company providing nonemergent transportation services on behalf of Healthy Blue.

https://provider.healthybluene.com

BNEPEC-0404-20 December 2020

You're invited!

Provider coding education (CME/CEU)

Webinars are now available!

You can access all provider-coding education events for Healthy Blue with one easy convenient link: **Register here**.

We will add new topics to the training page, so please check it often. Enjoy informative webinars designed specifically for network providers, coders, billers, and office staff. A variety of helpful and educational topics relating to coding and documentation, claims and billing issues, member care, quality measures, and more are available.

Live events: Each live training webinar event offered awards one unit of continuing education.

Upcoming topics include:

- Cultural competency.
- 2022 coding updates.
- Social drivers of health.
- Telehealth.
- BH and Substance Use Disorders.

AAFP CREDIT SYSTEM APPROVED

AAPC CEU APPROVED

Register today; you will not want to miss these exciting opportunities. There are two easy ways to register. Please reserve your place at least 24 hours prior to the start of the event.

Access the training page by following this link: **Register here**

1. You may also access the page using the QR code:
   - Use the camera on your device to capture the QR code. A link will appear. Tap the link to open the training page.

Healthy Blue | HERITAGE HEALTH

BNE-NL-0138-22-B April 2022 State approval: 03/15/2022

Providing Food as Medicine

Healthy Blue partners with organizations across the state, including the Food Bank of Lincoln and the United Way of Western Nebraska, to provide healthy food to families statewide.

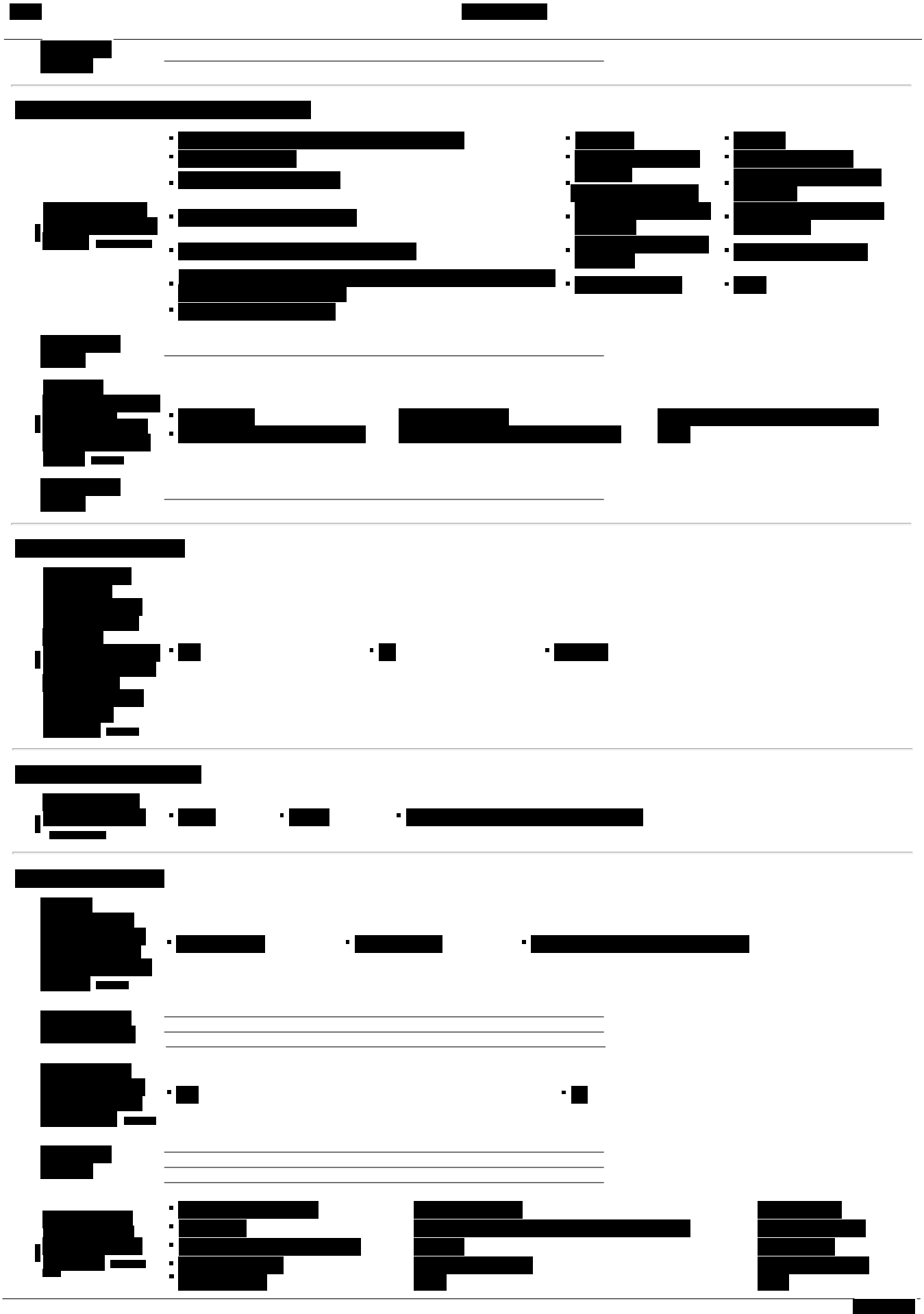
Attachment V.L.52-1: Health Risk Assessments

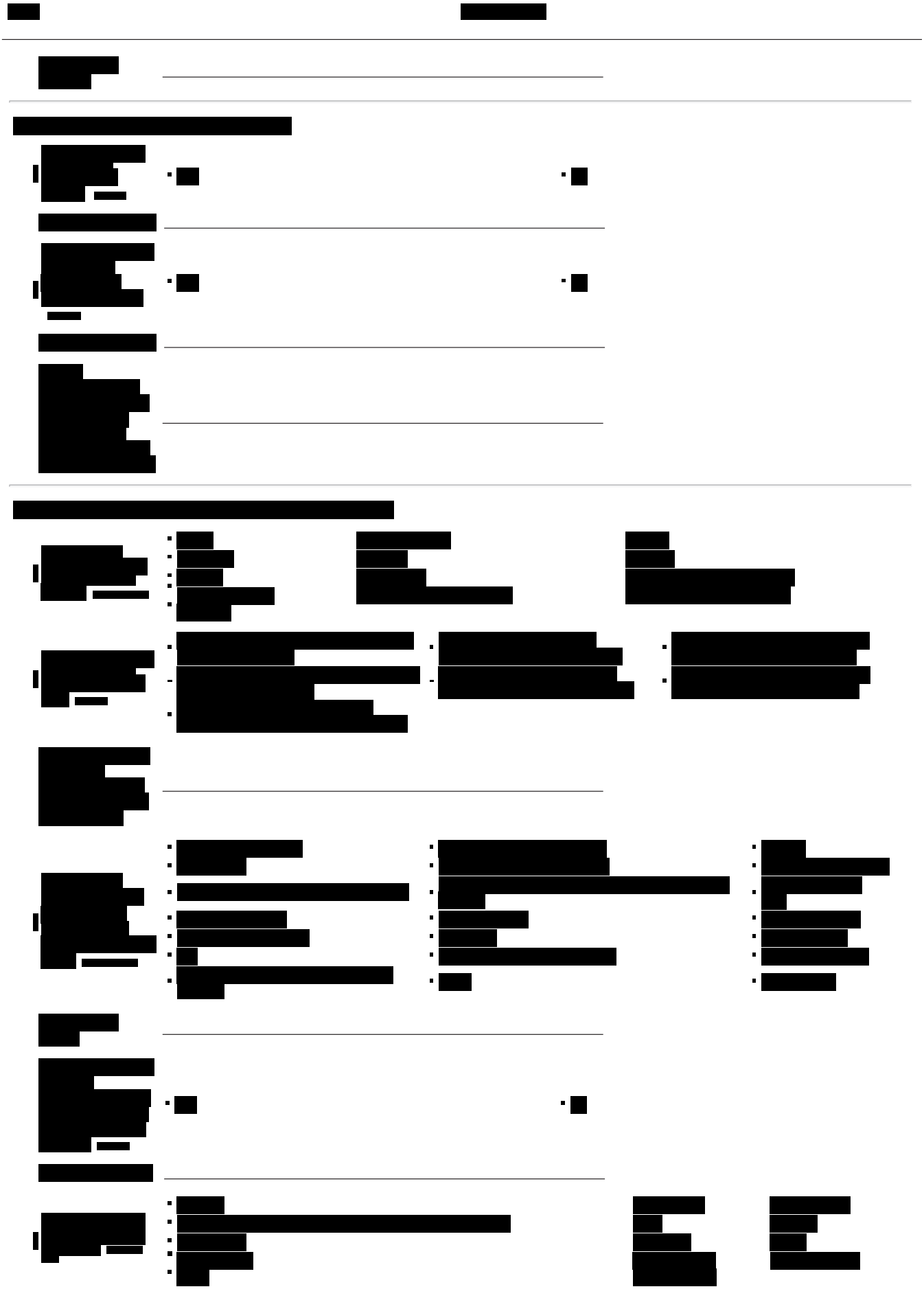
Healthy Blue

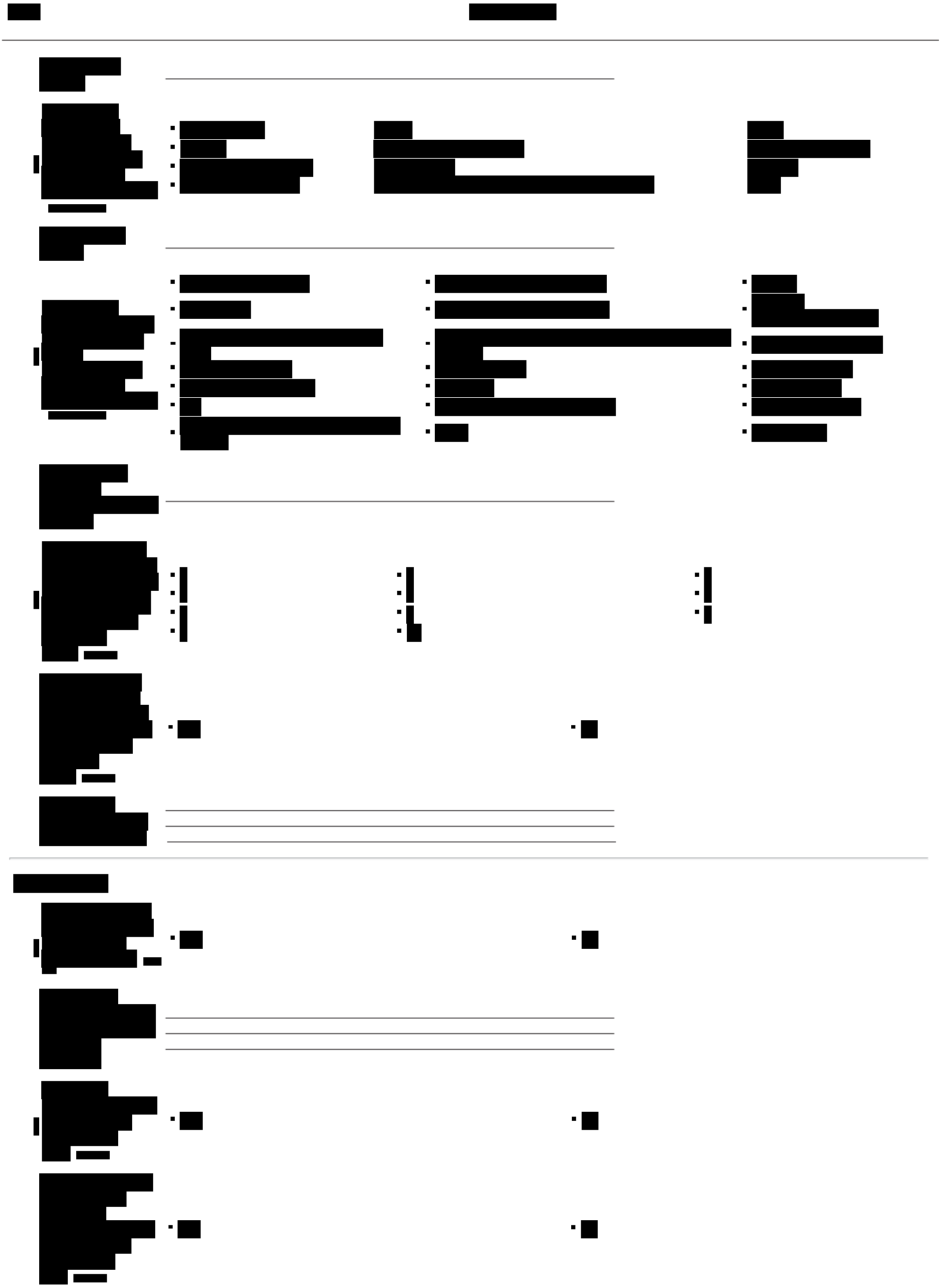
Attachment V.L.52-1: Health Risk Assessments

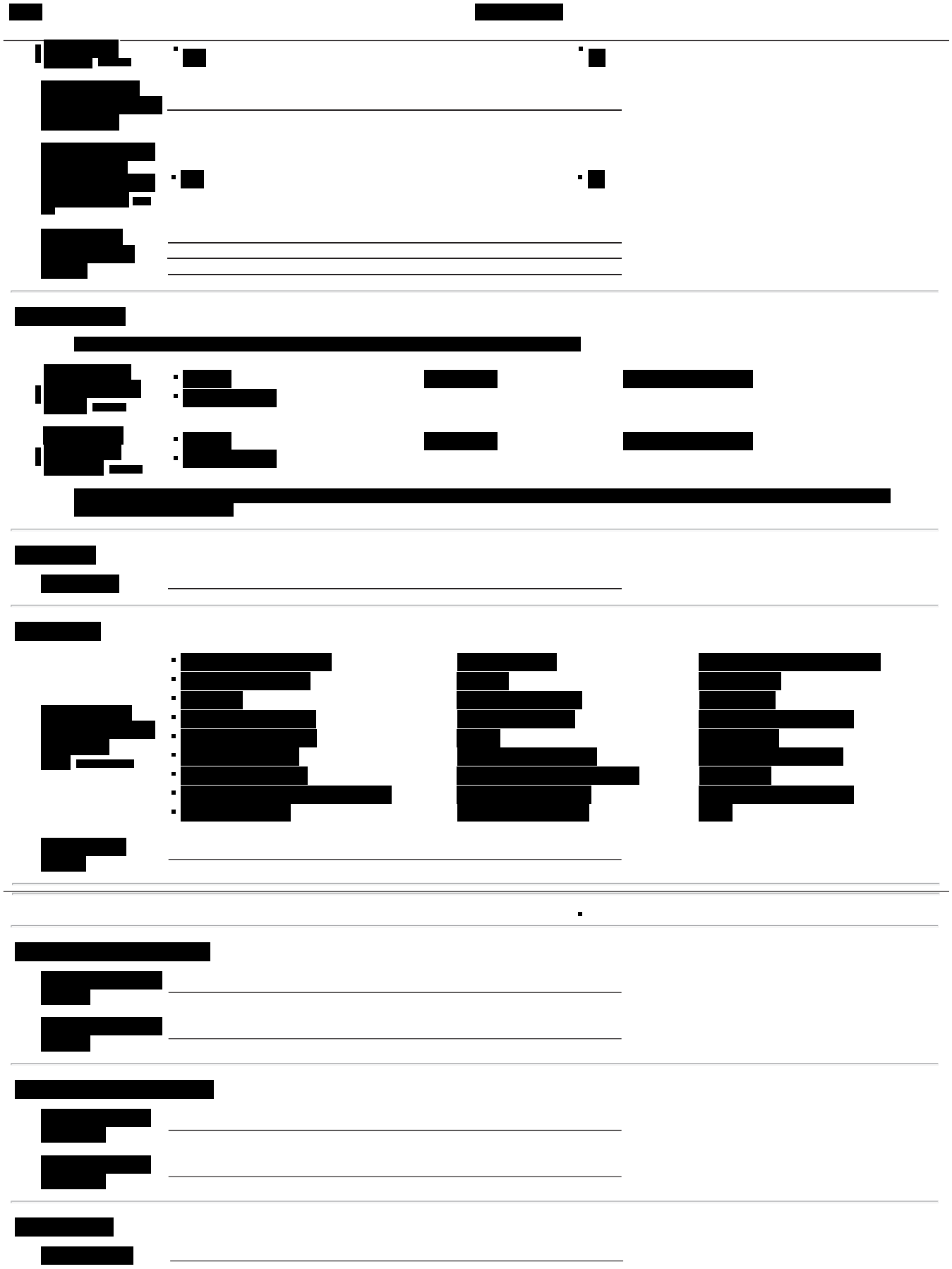
Healthy Blue has provided the following Health Risk Assessment (HRA) templates to best address individual member needs identified in the Health Risk Screening (HRS) process

- Physical Health
  - Adult Care Management Initial Assessment
  - Pediatric Care Management Initial Assessment
- Behavioral Health
  - BH General Adult Assessment
  - BH General Pediatric Assessment
- Pregnant Members
  - 2020 OB High Risk Screener
  - Care Management OB Assessment
  - OB Postpartum Assessment
- Example of condition-specific Disease Management Assessments
  - Care Management Diabetes Assessment









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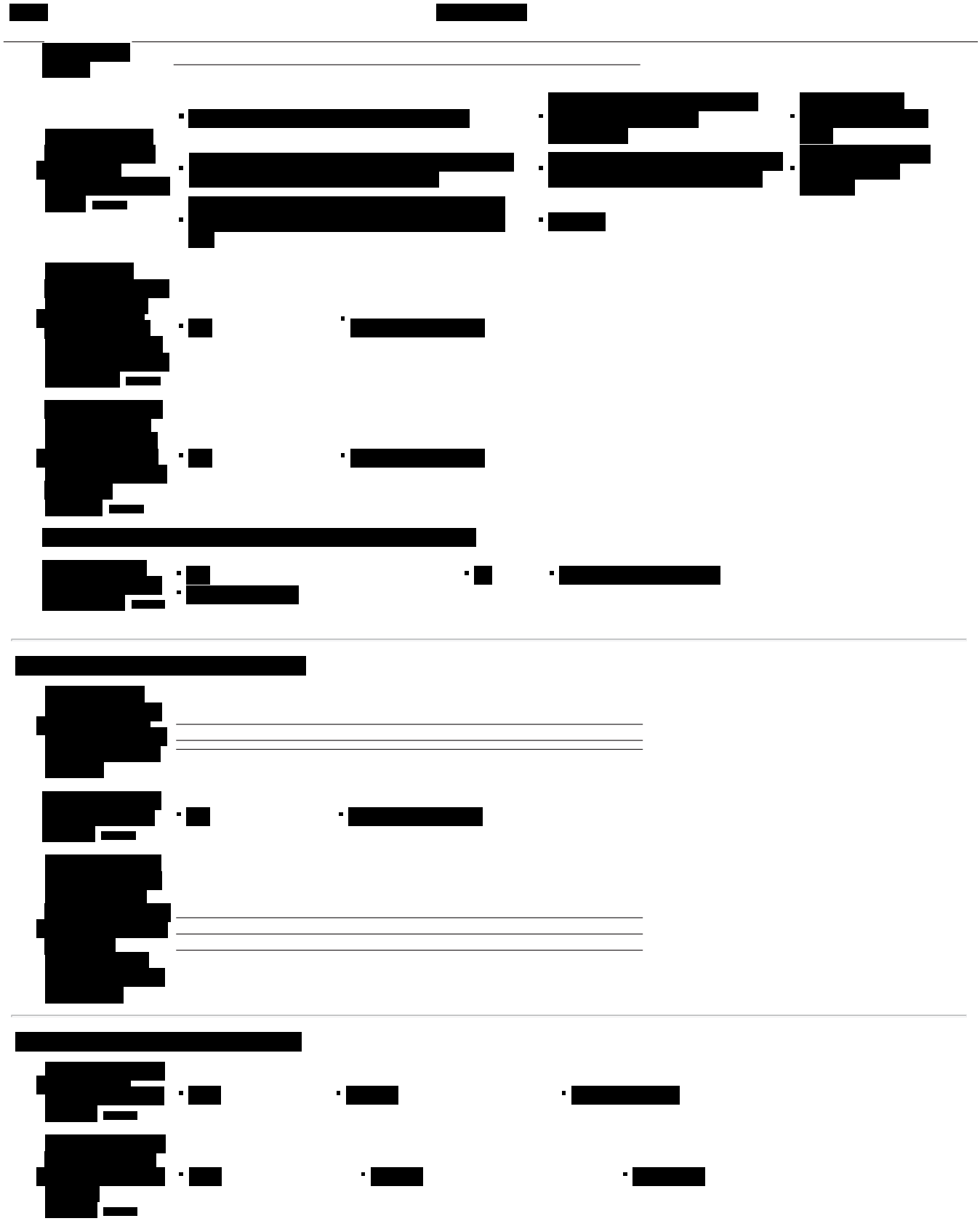
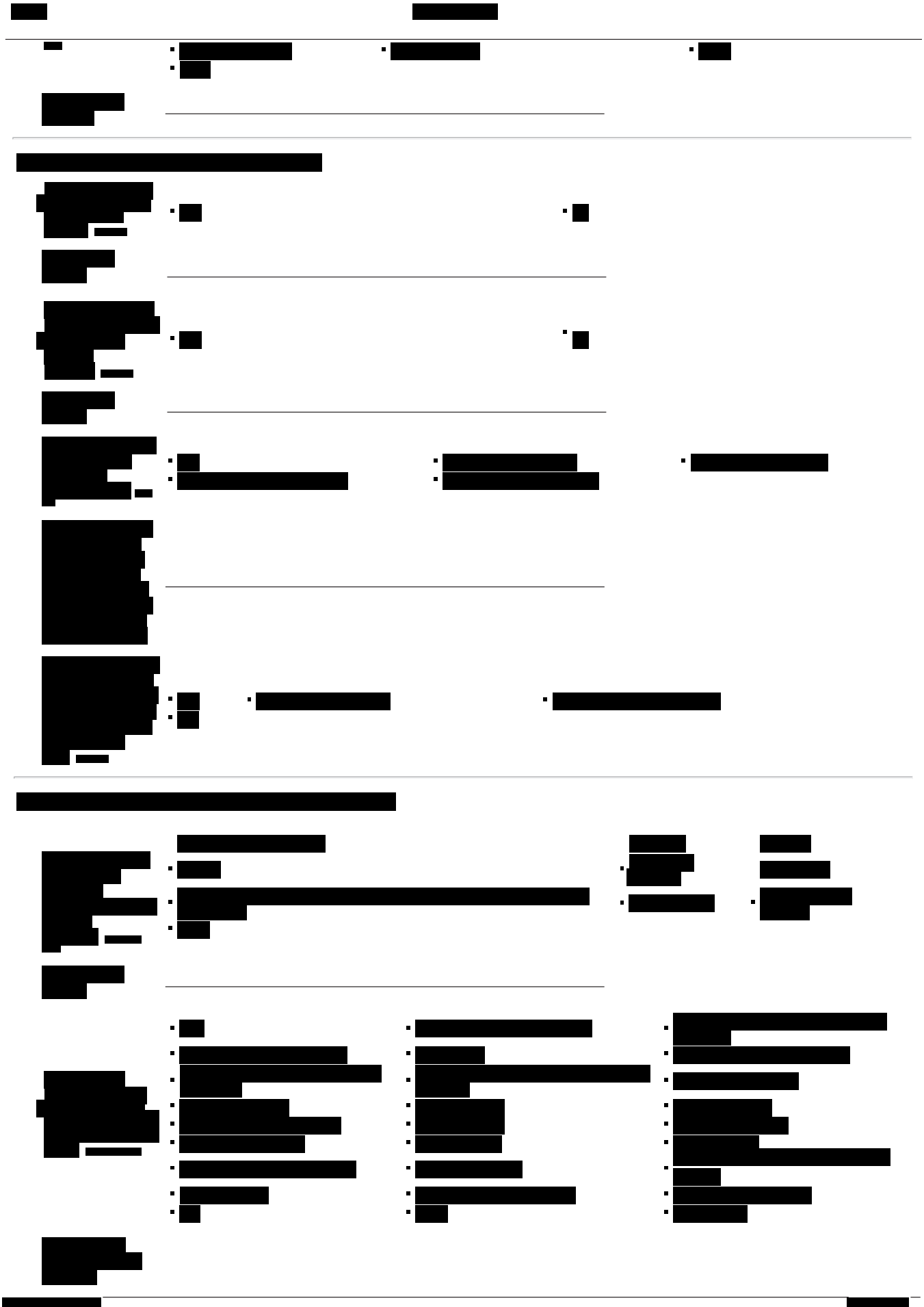
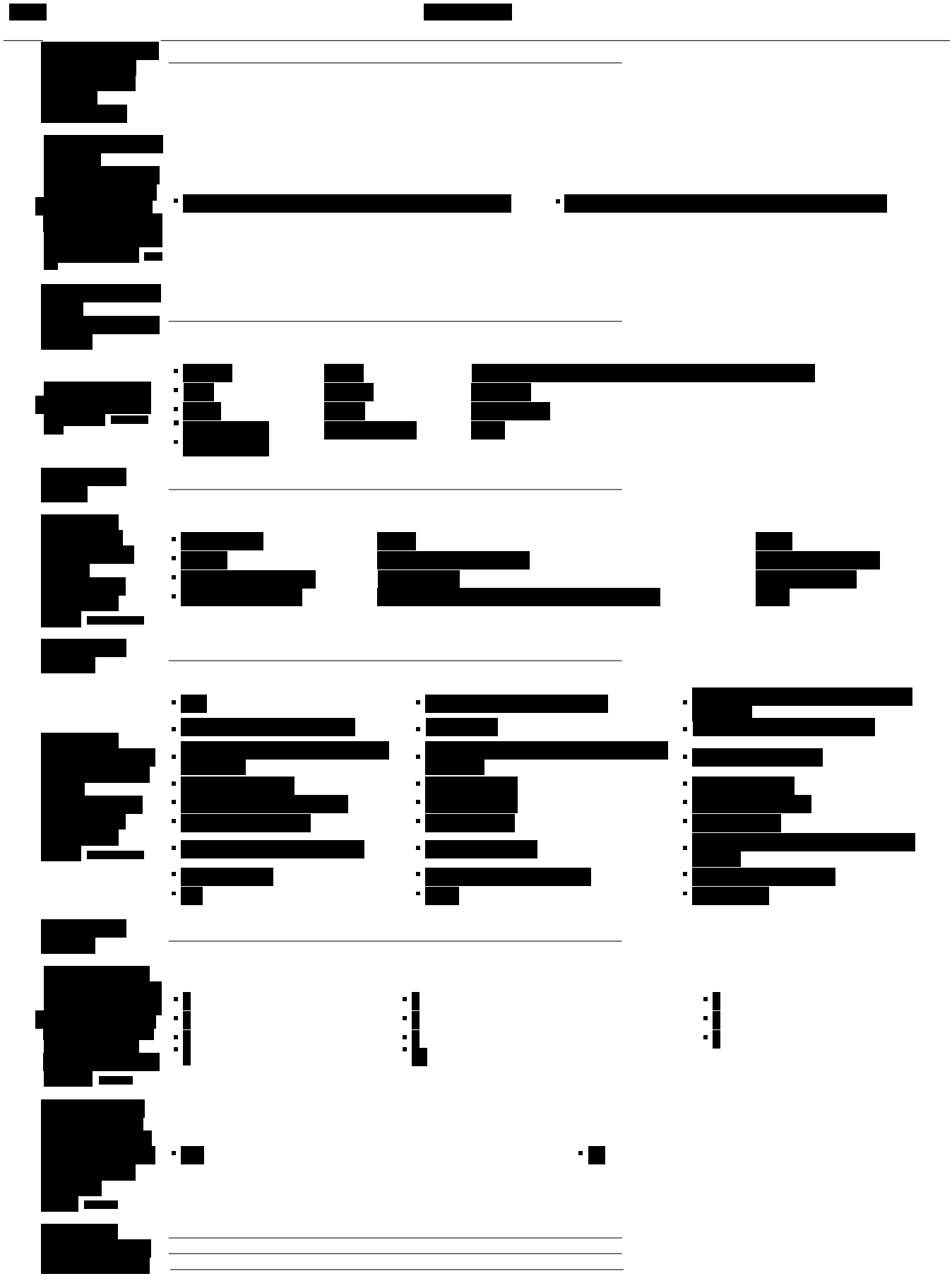
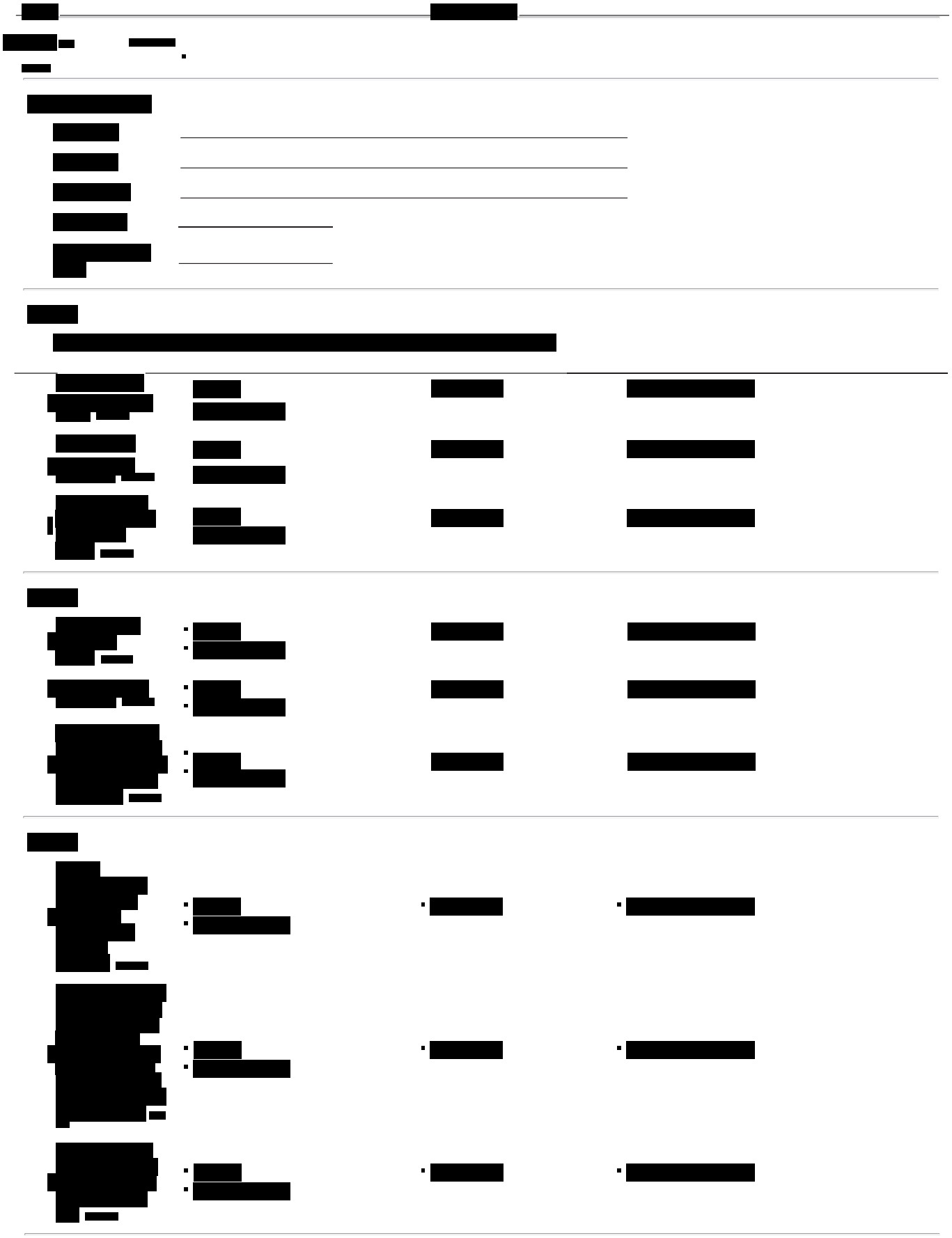
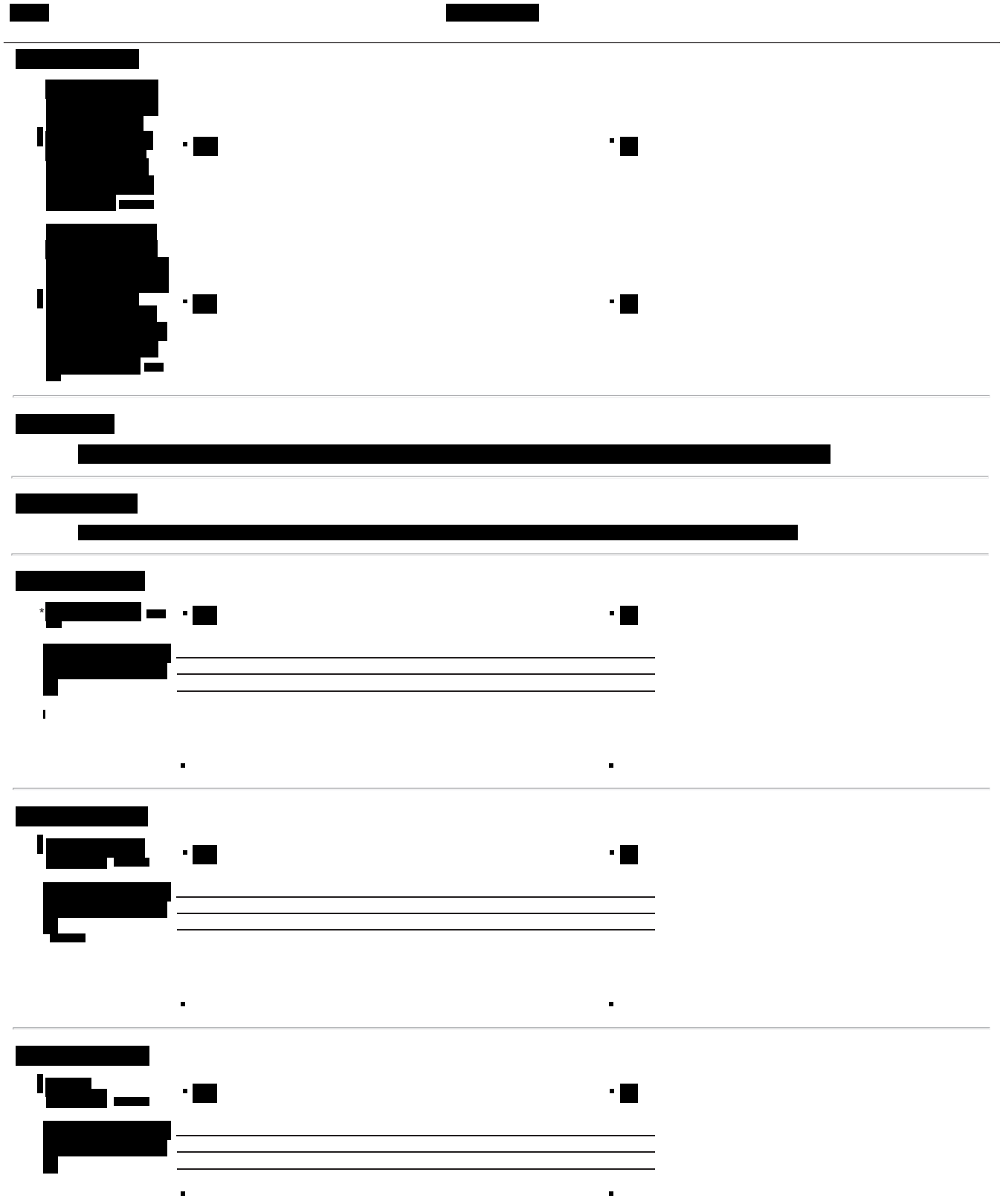
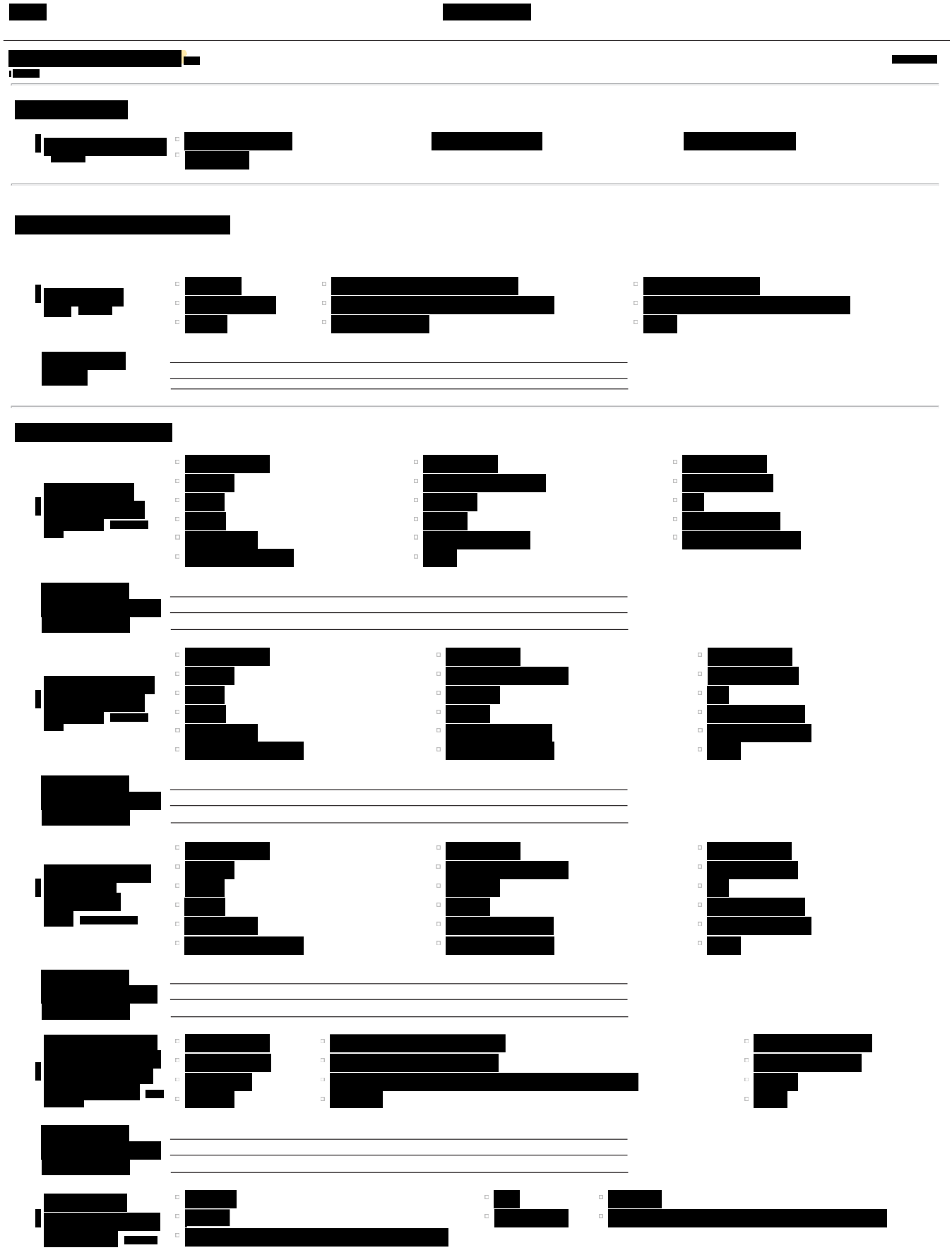


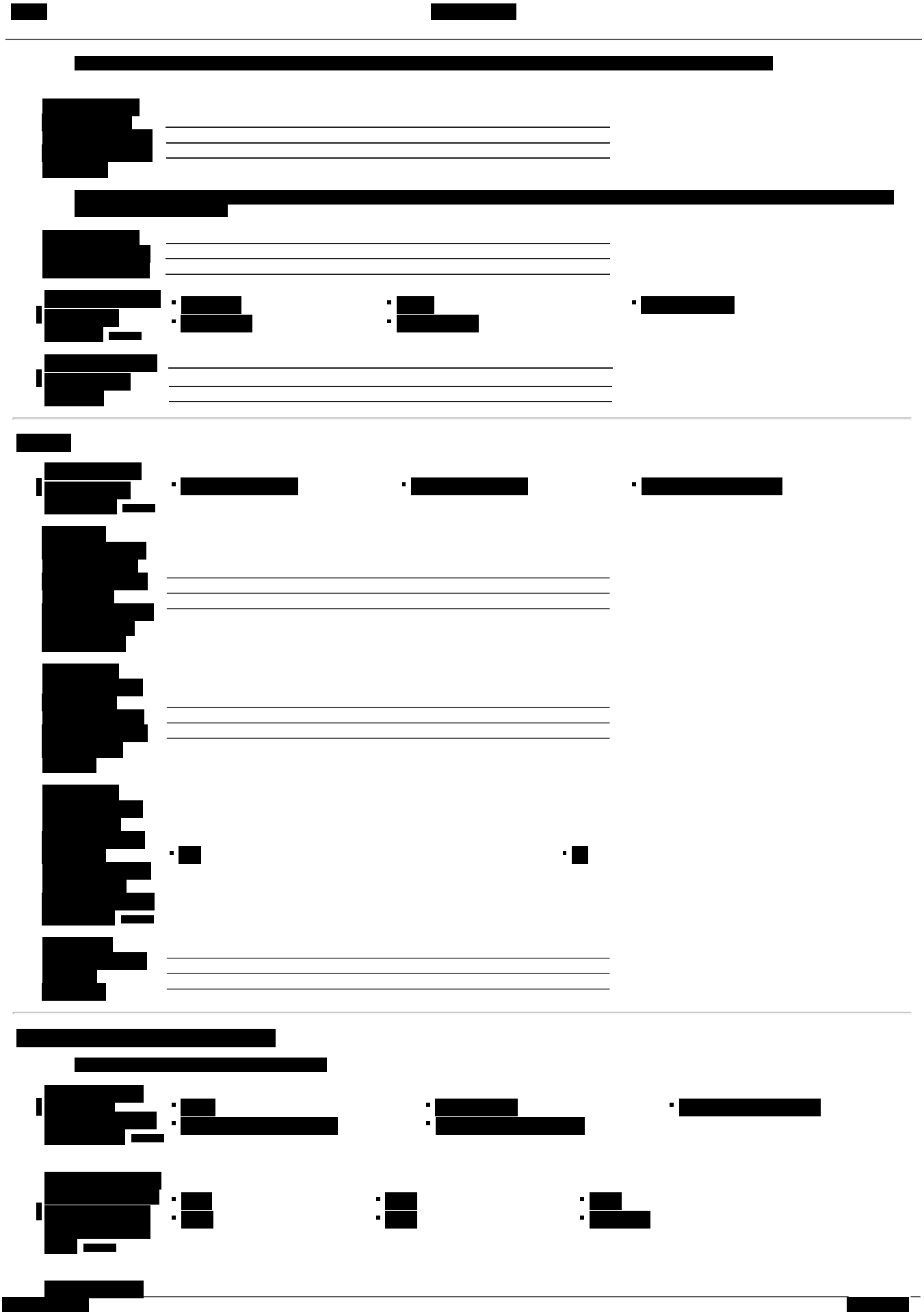


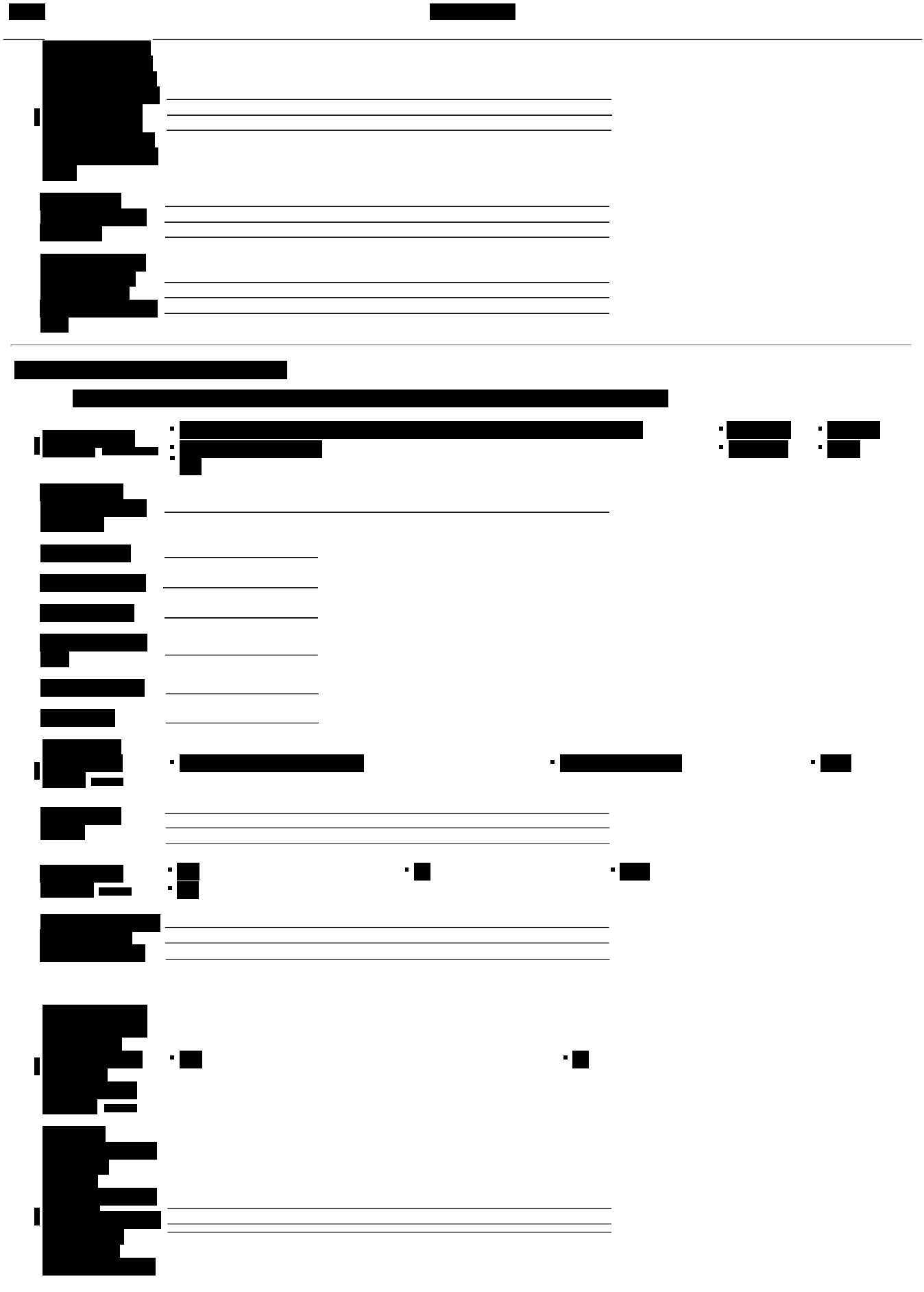


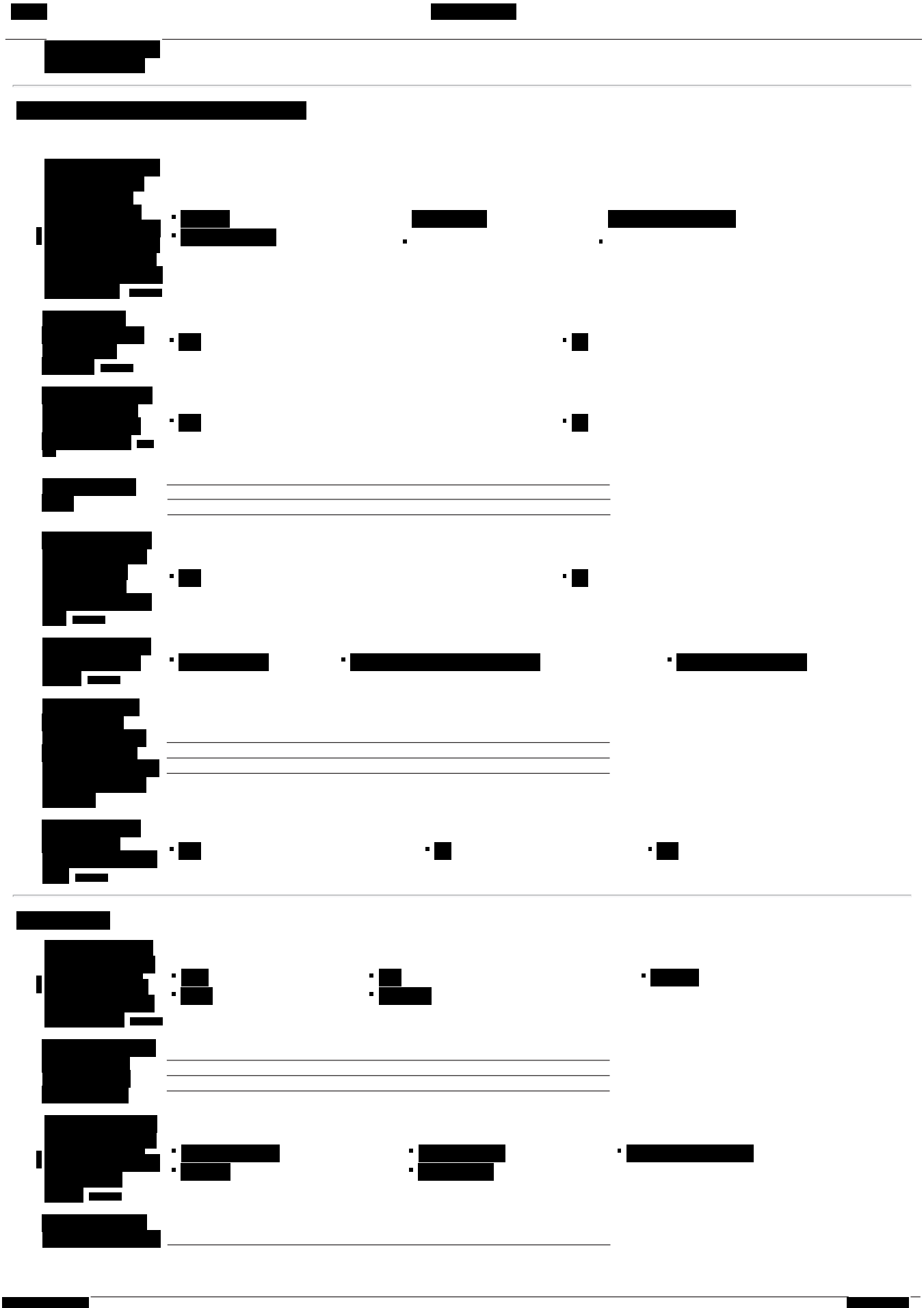


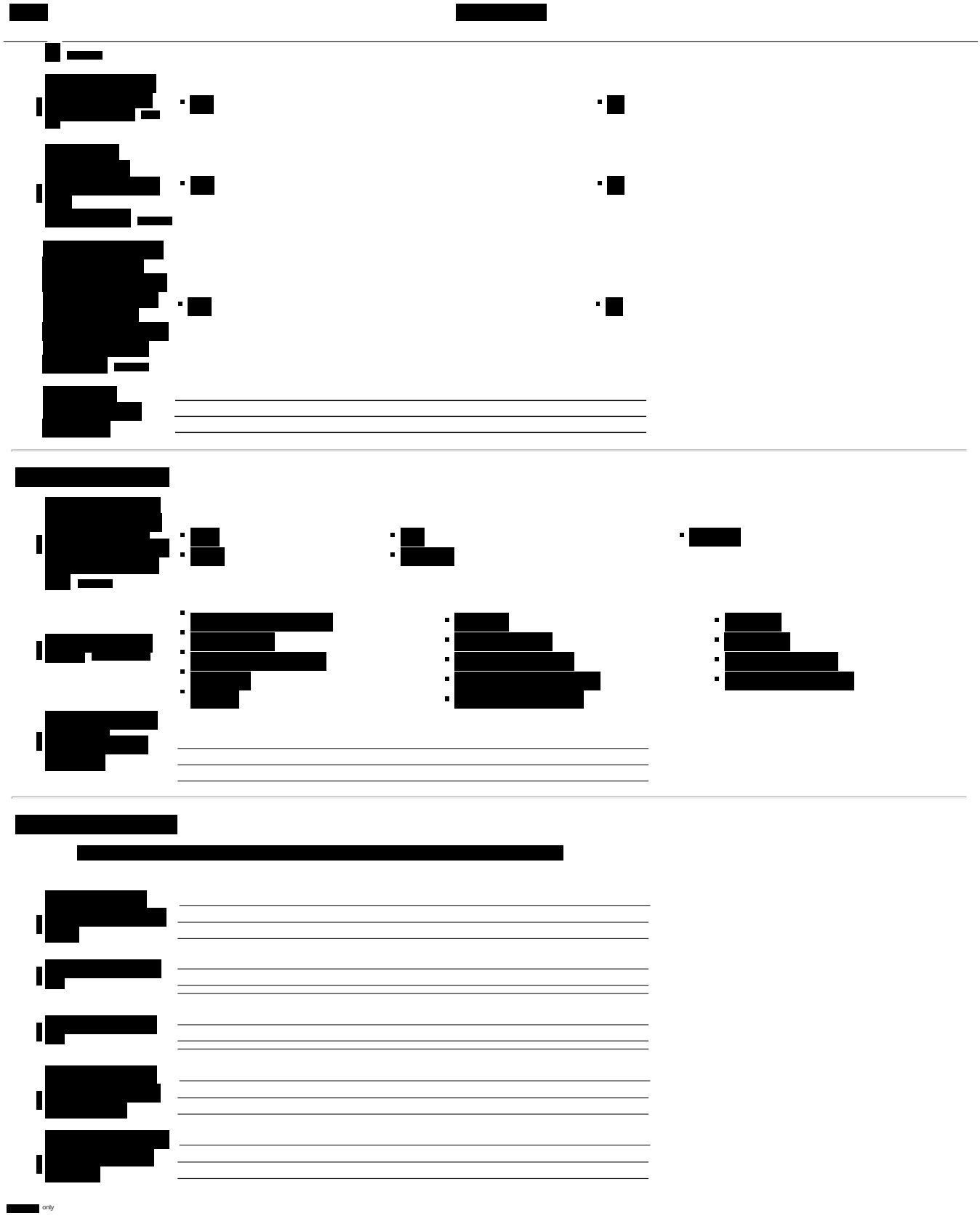


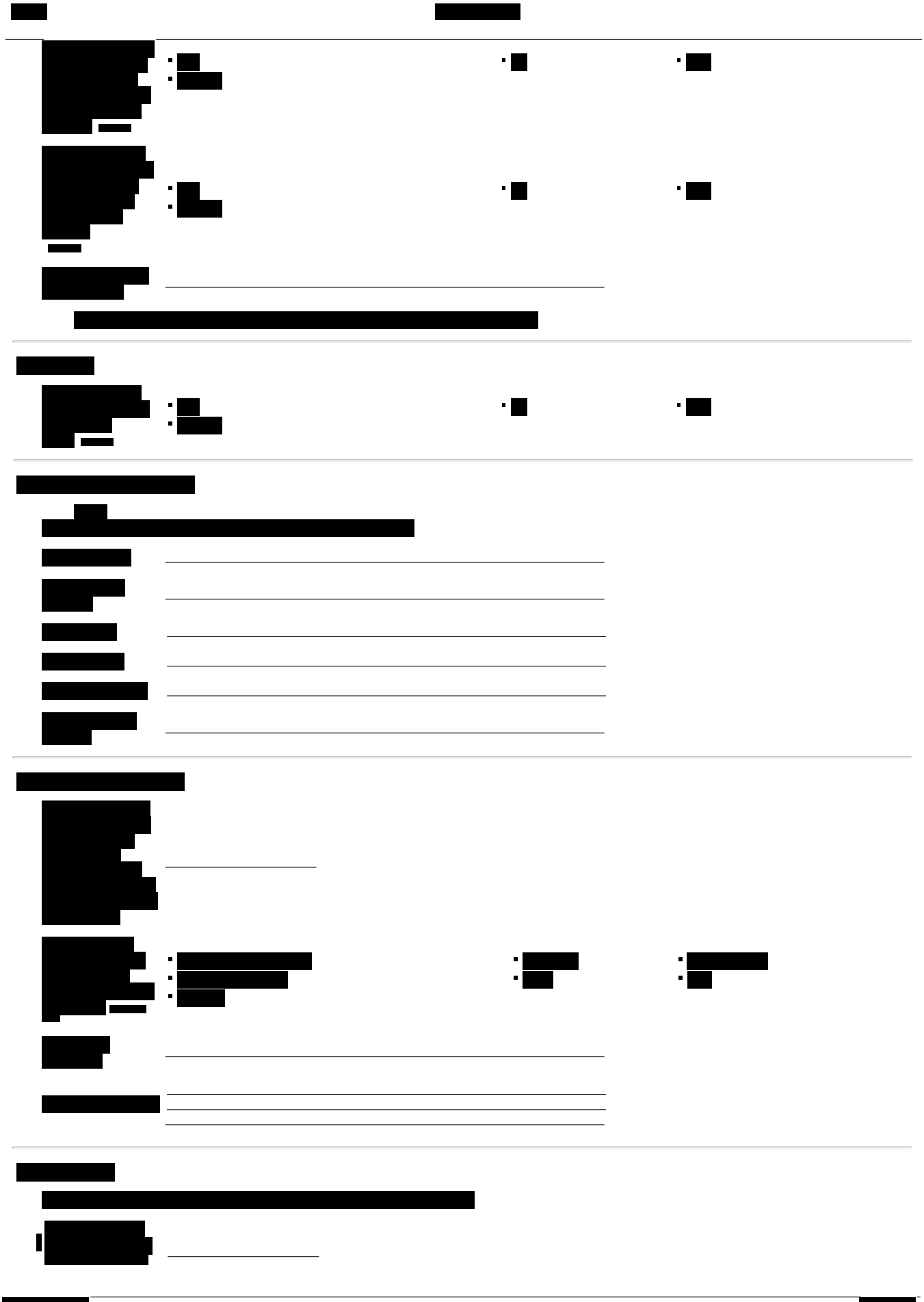


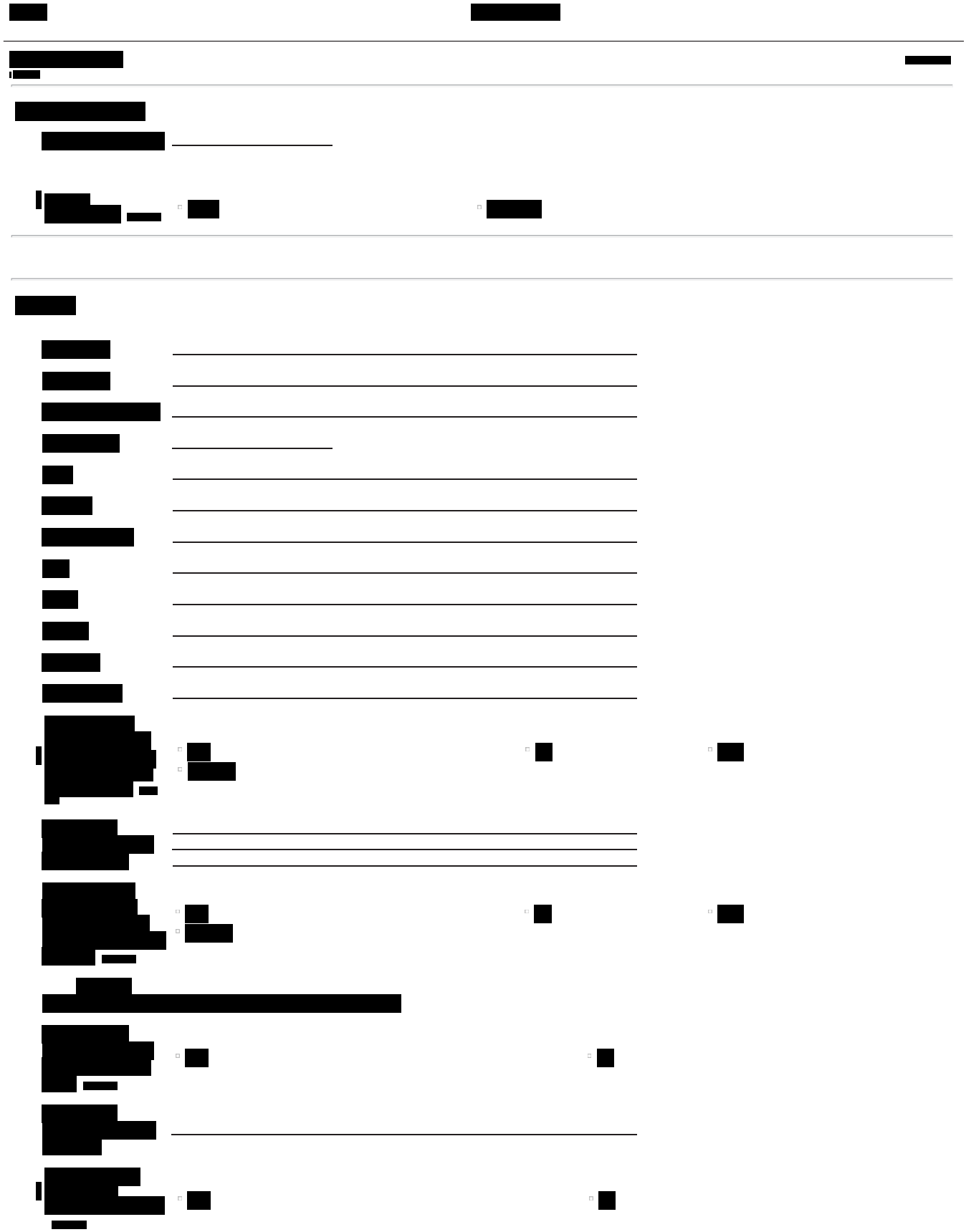


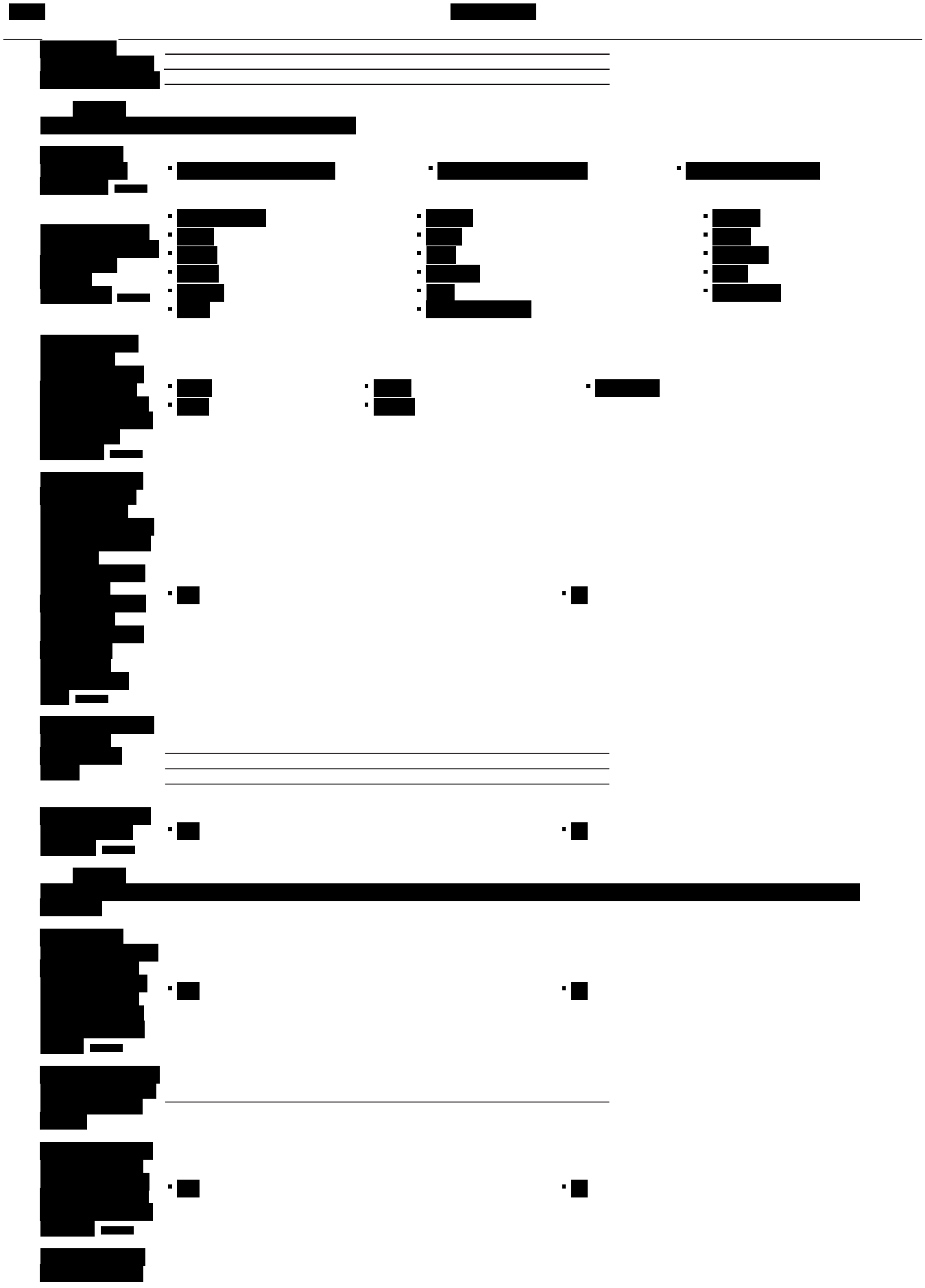


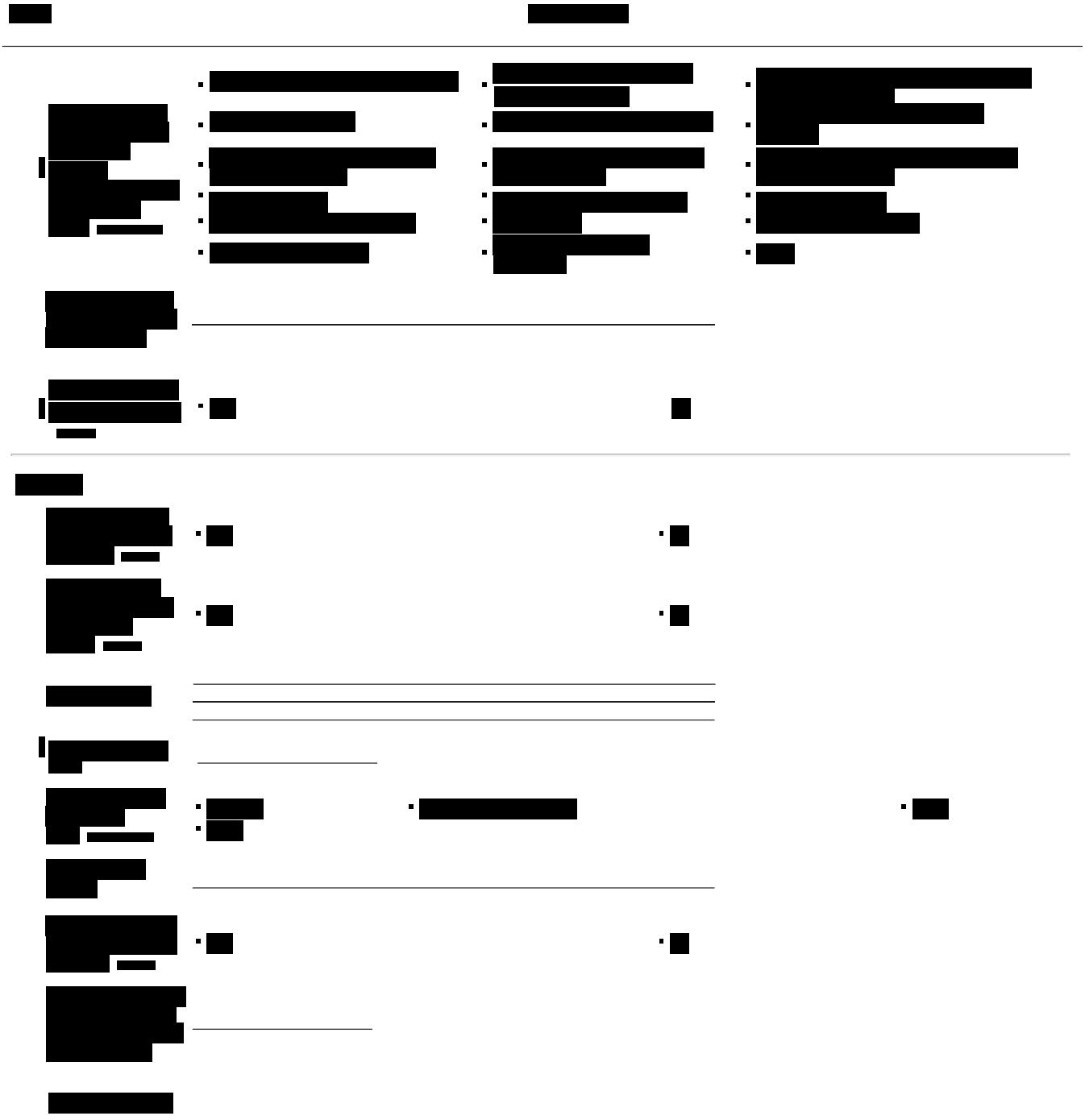


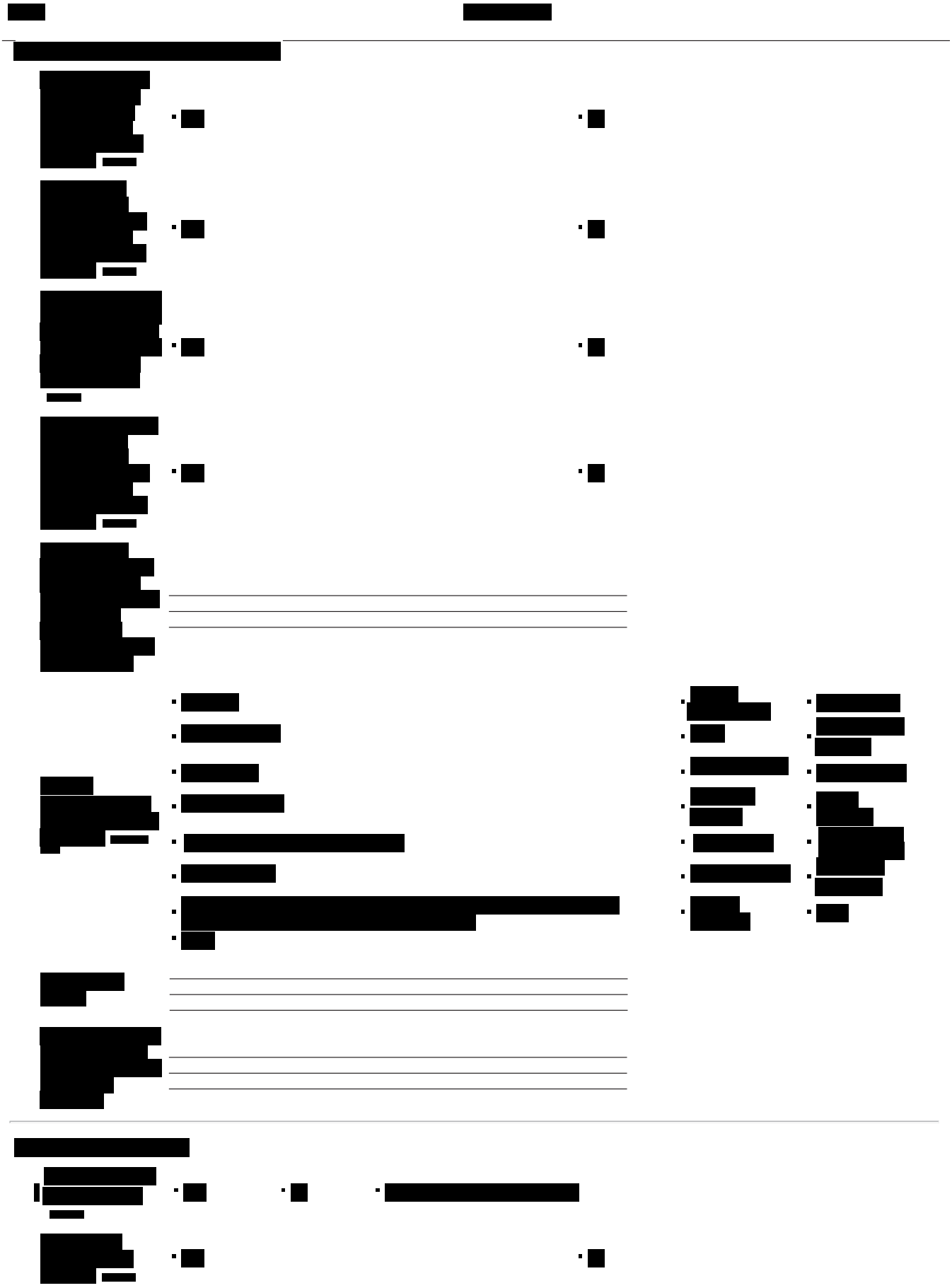


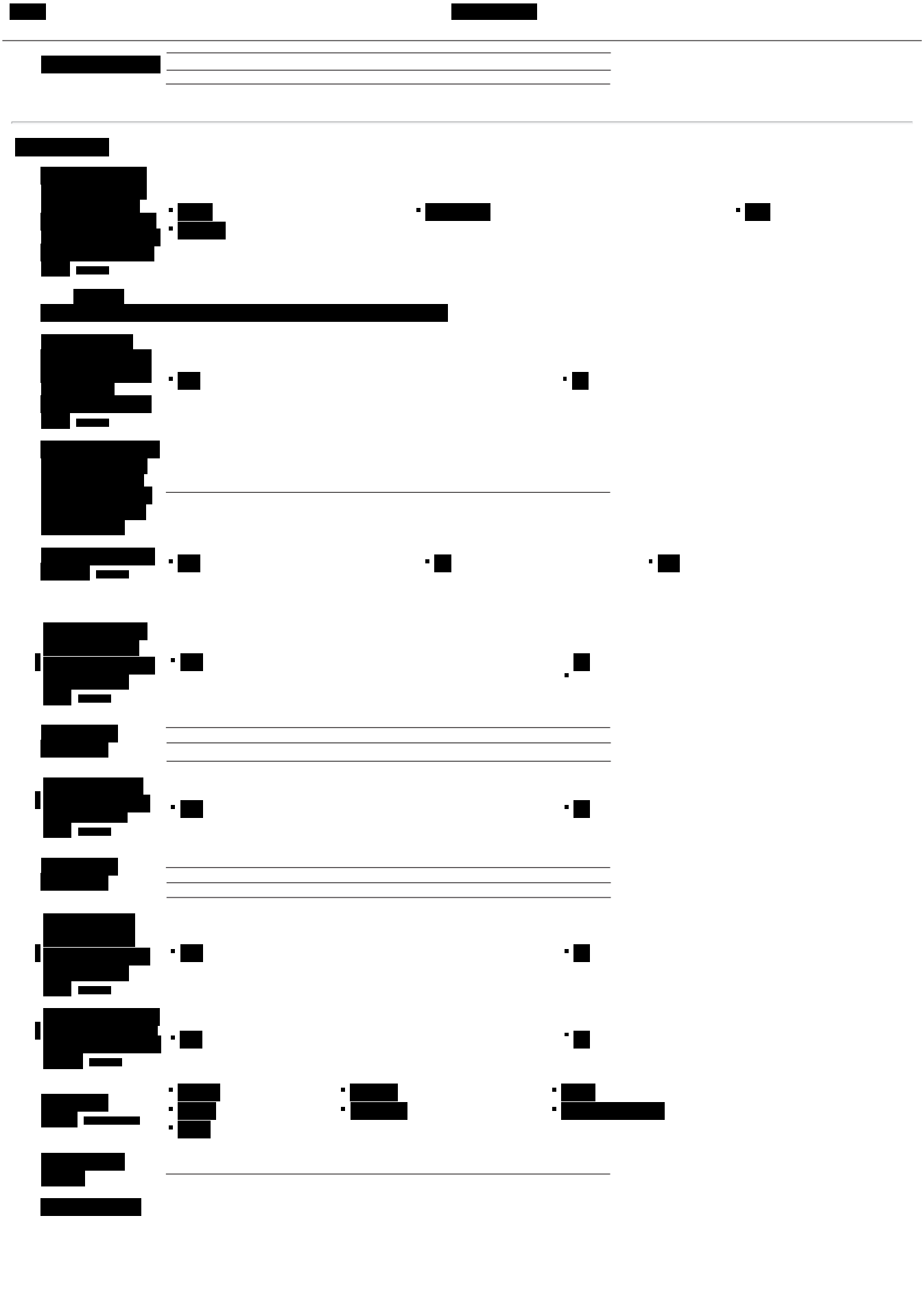


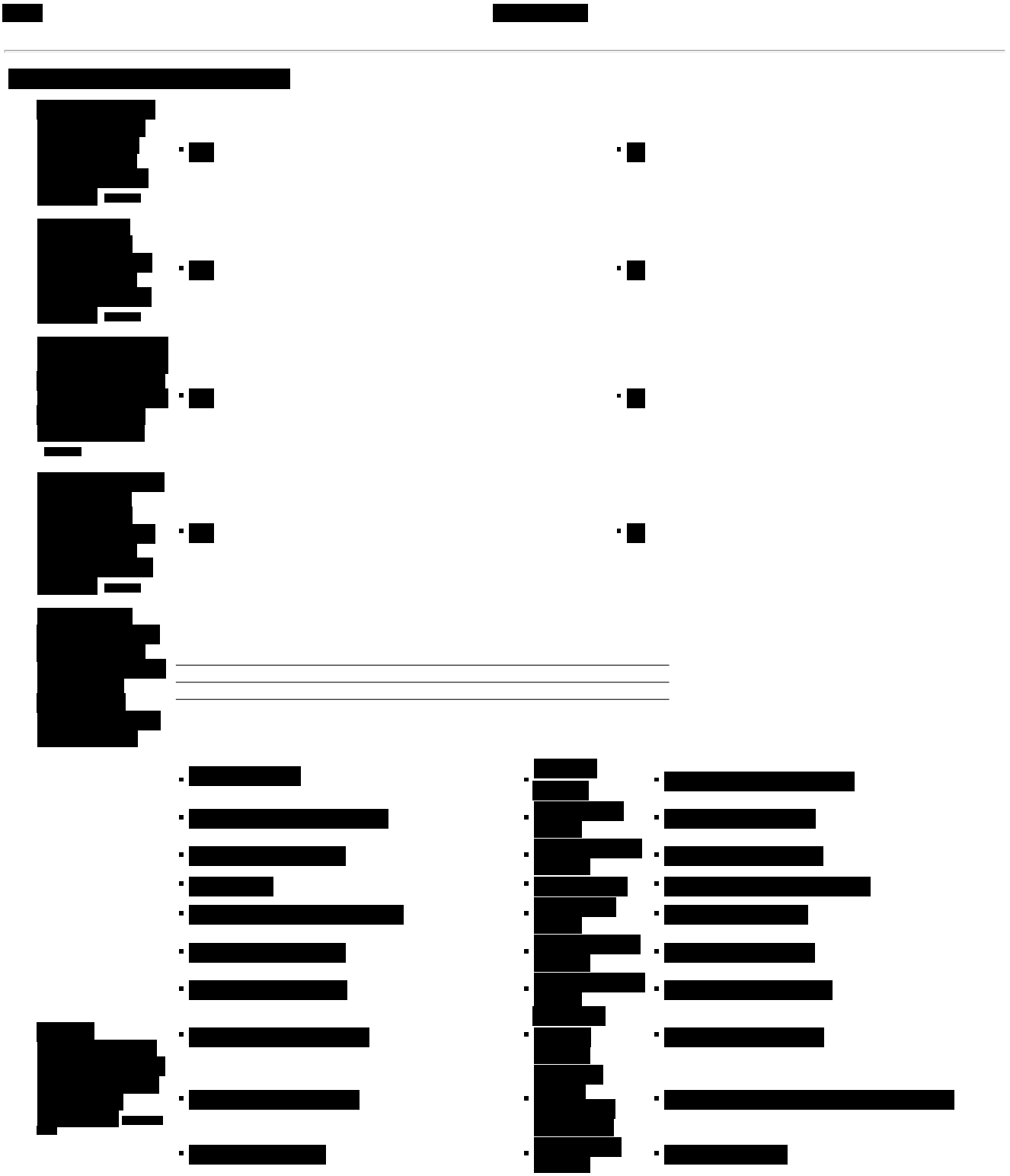


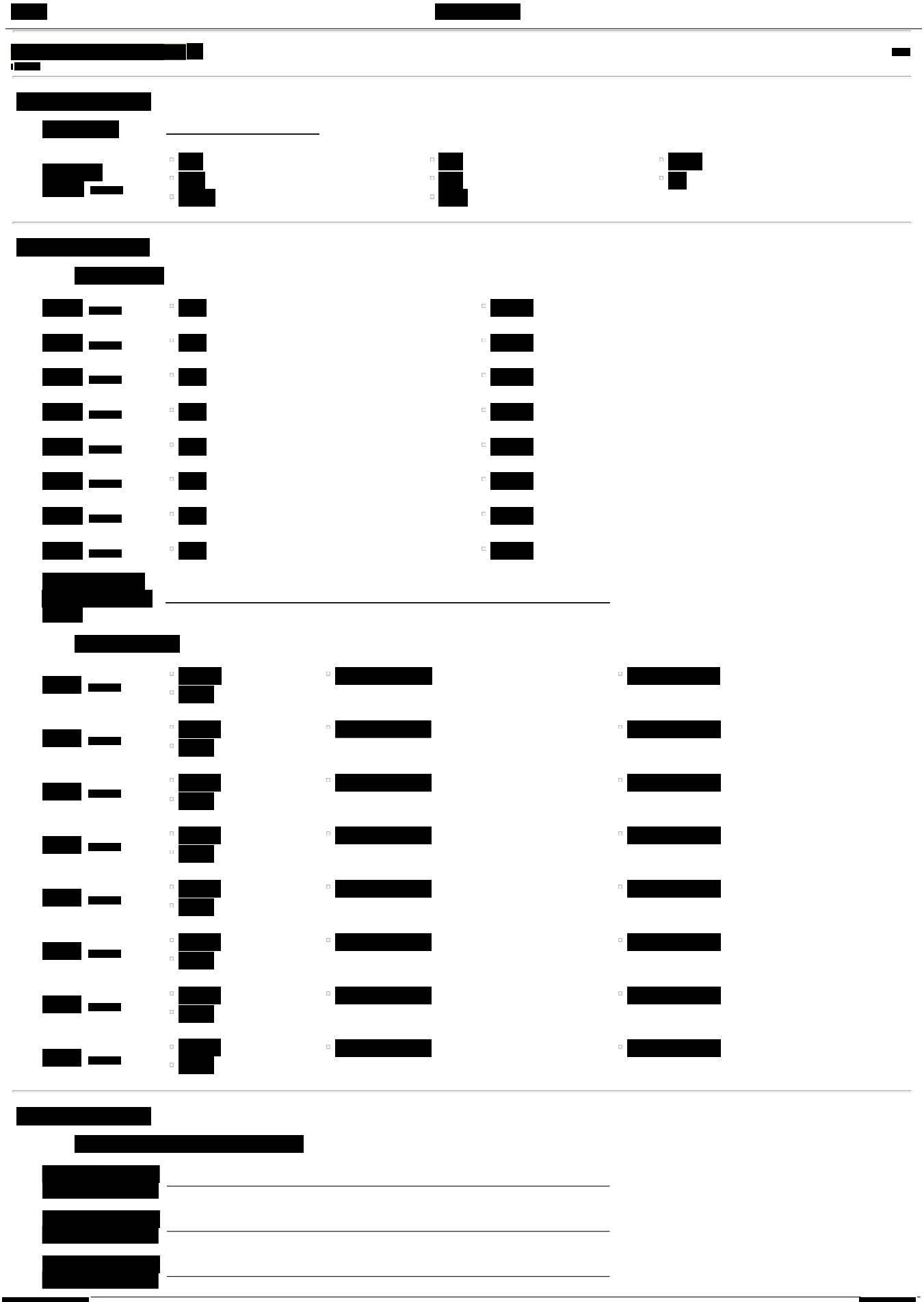


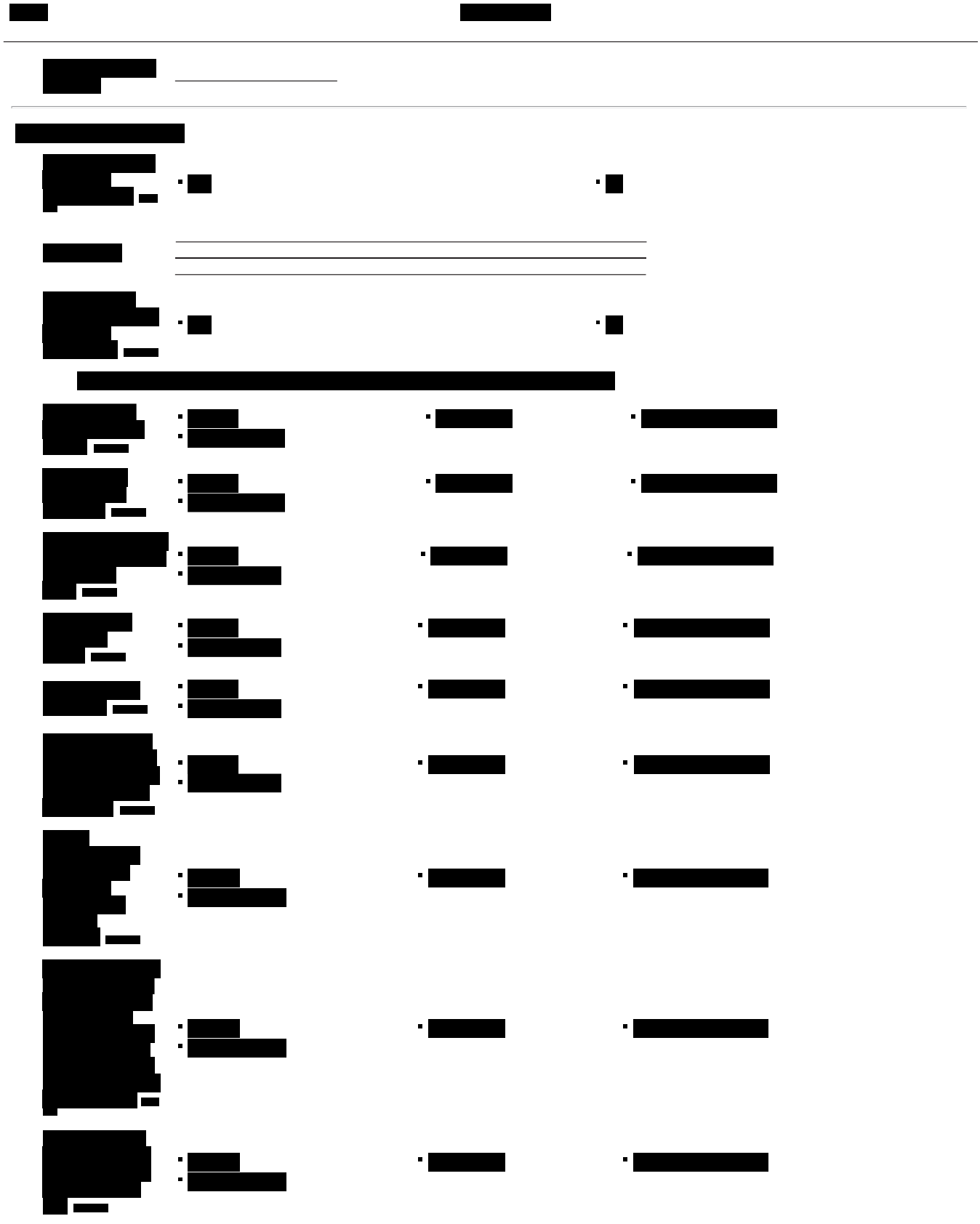


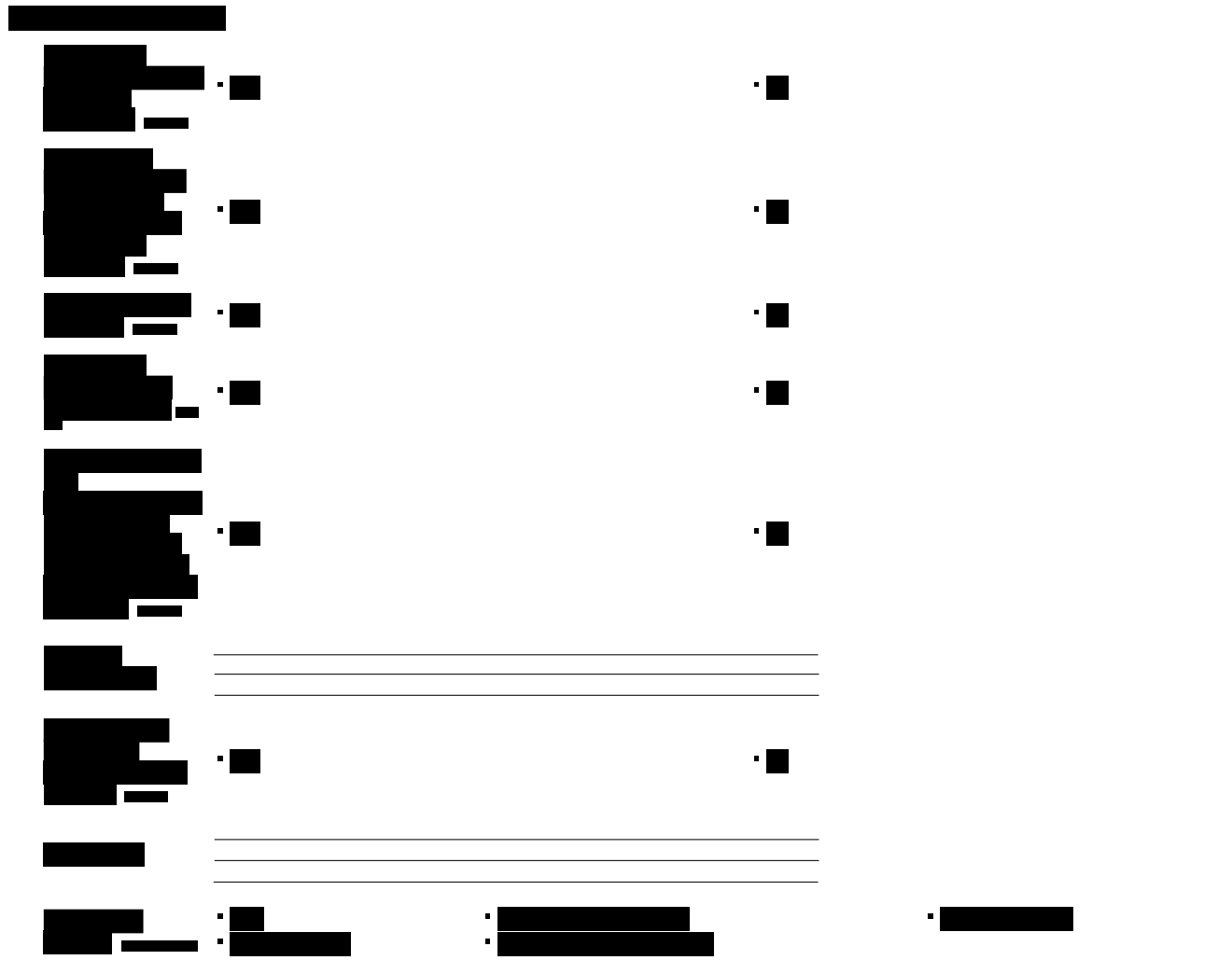


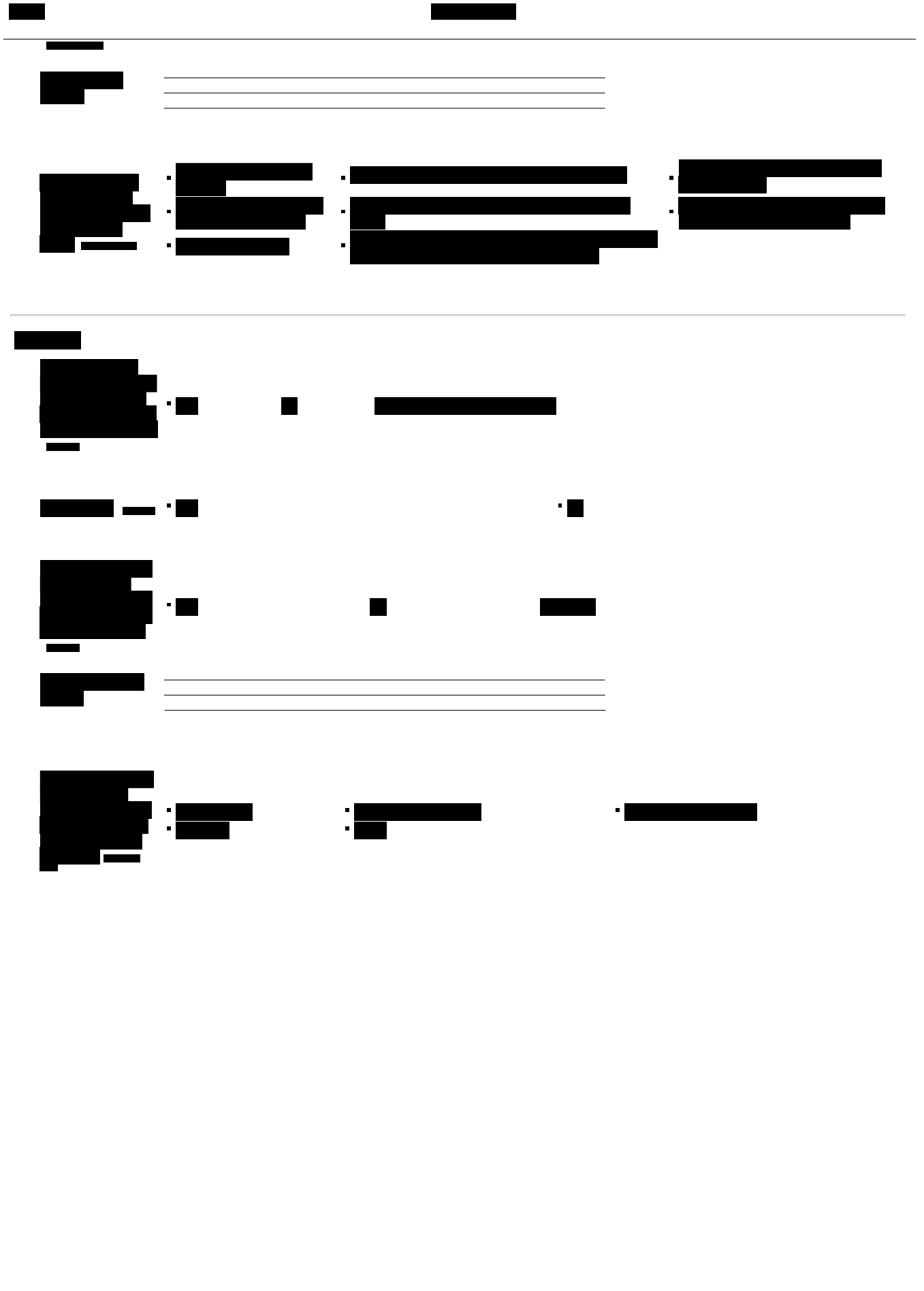


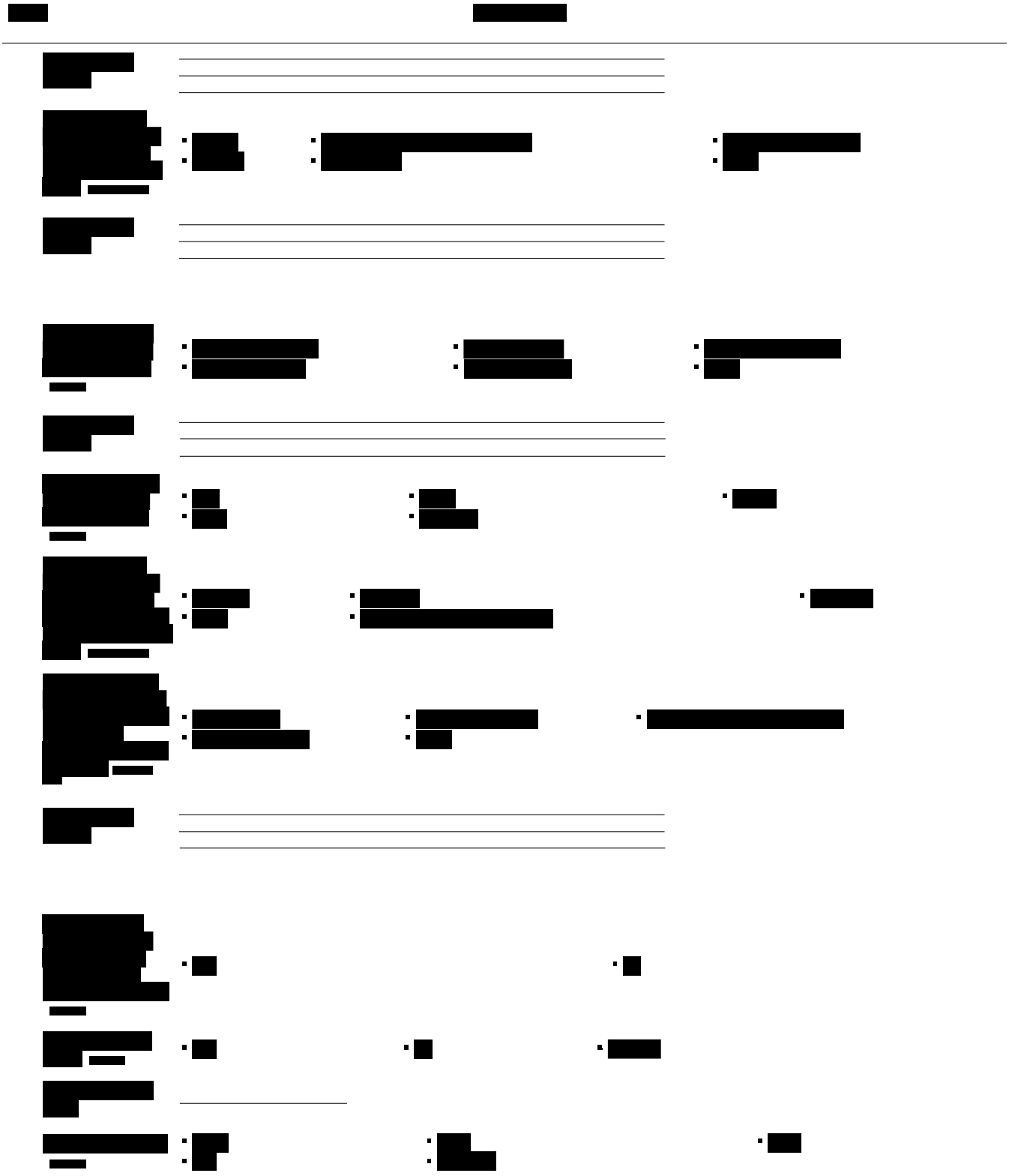


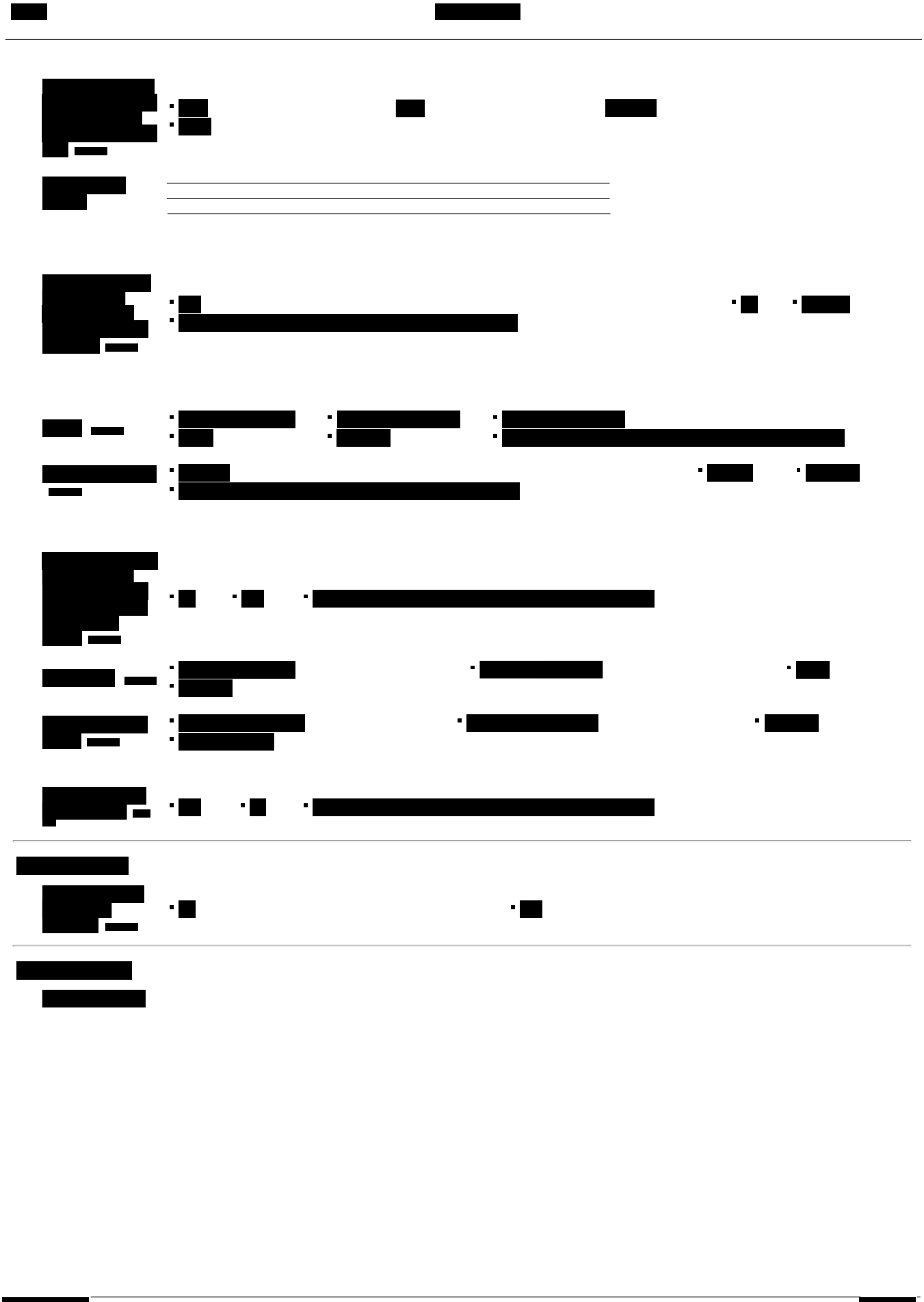


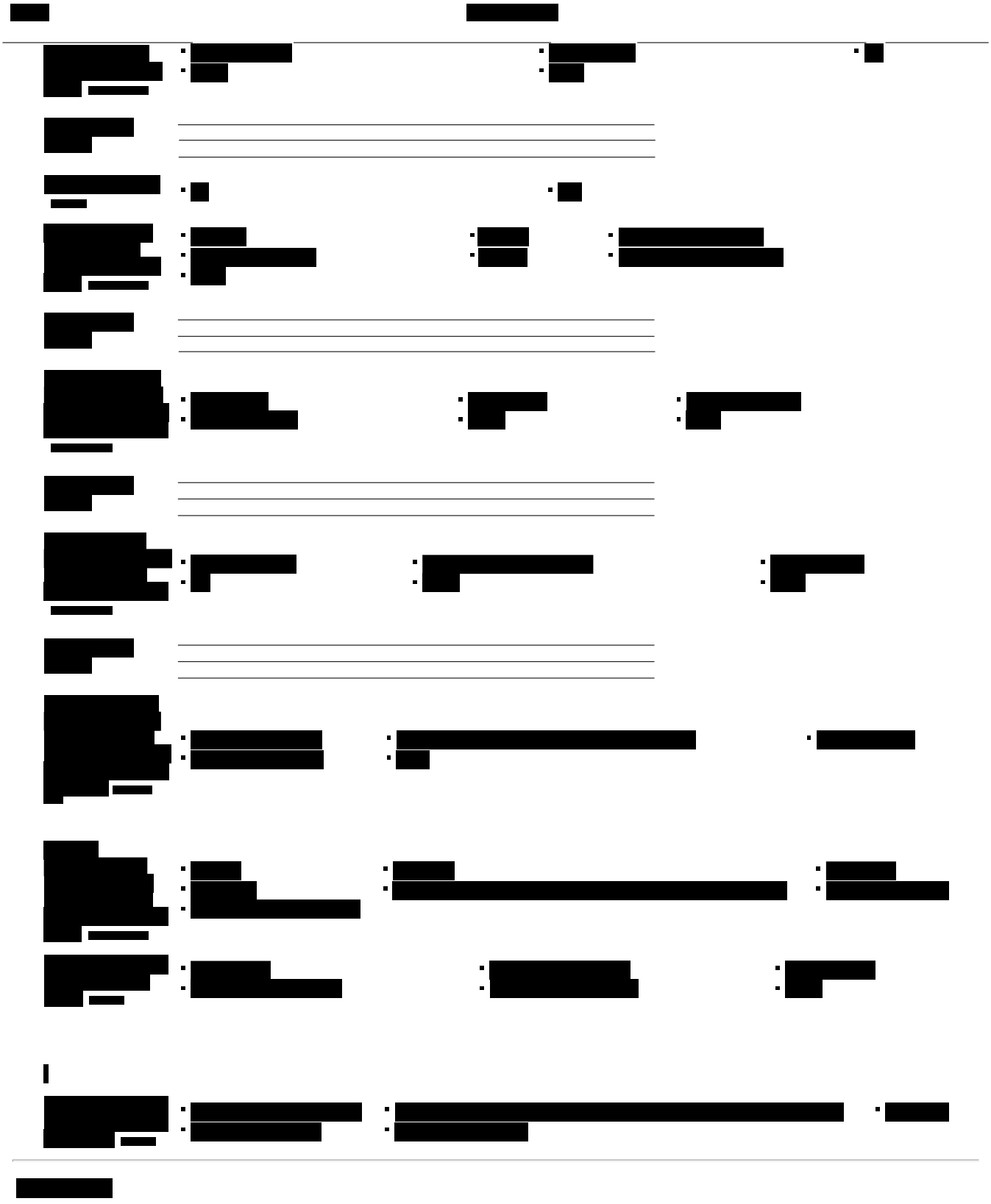


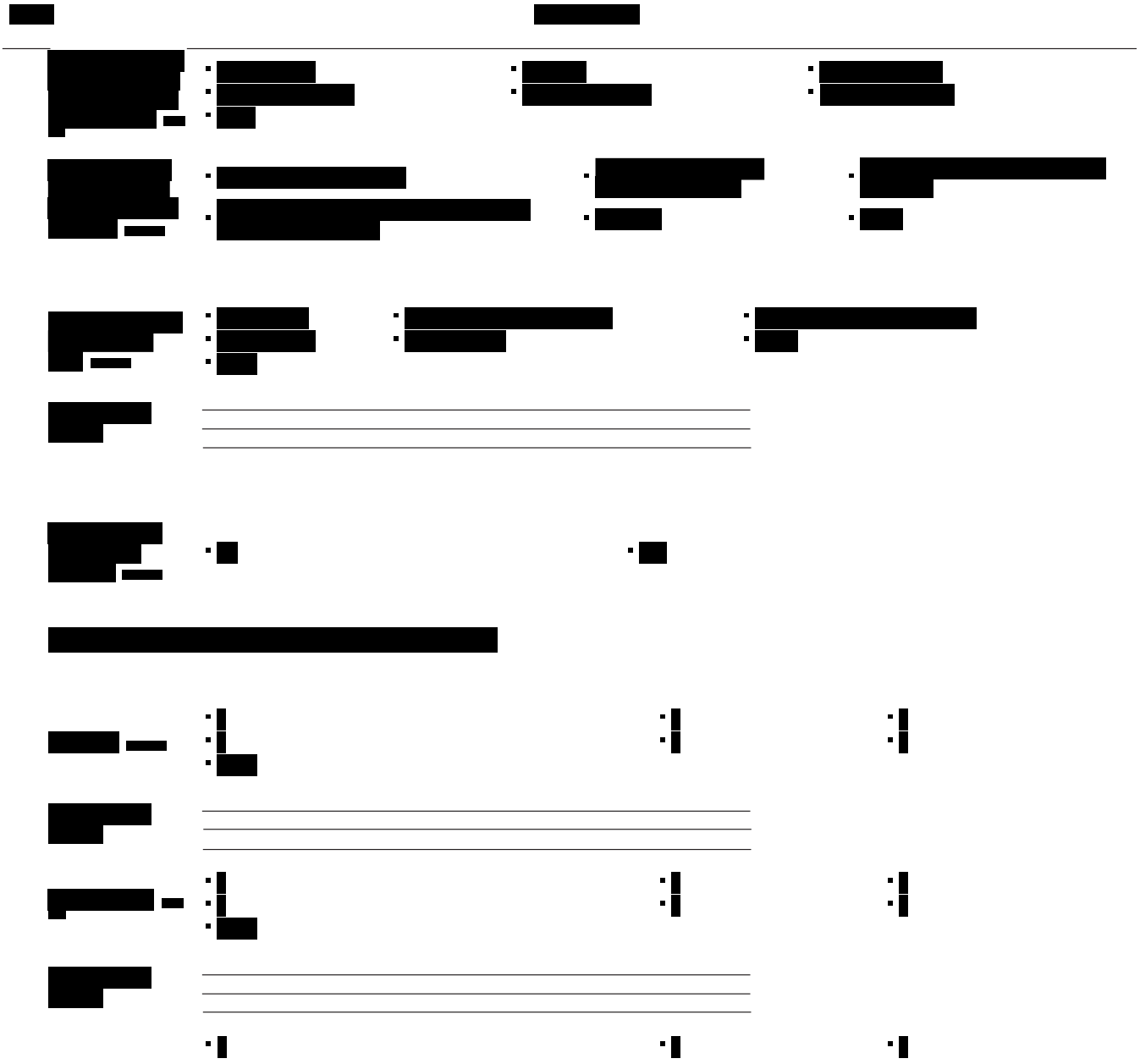


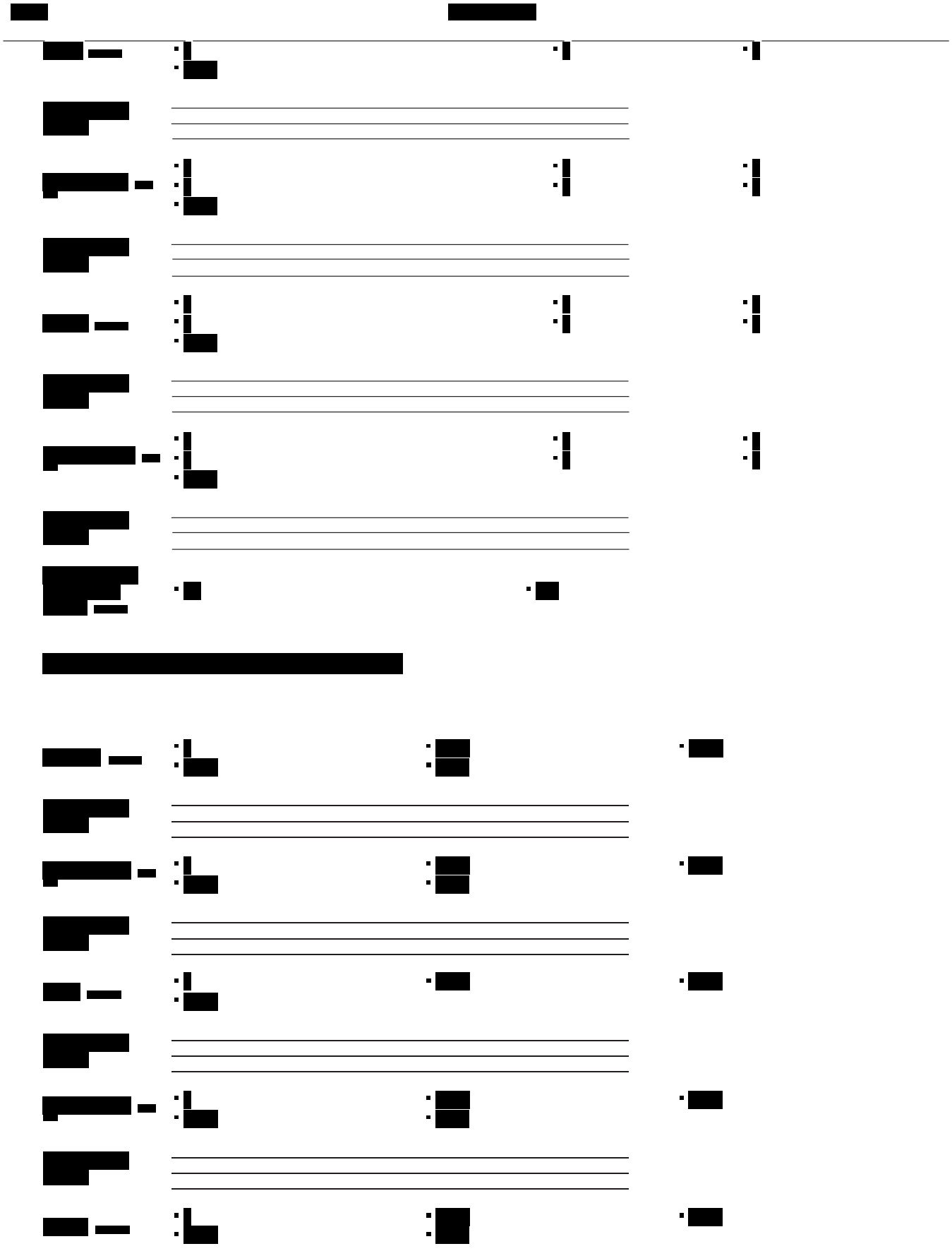


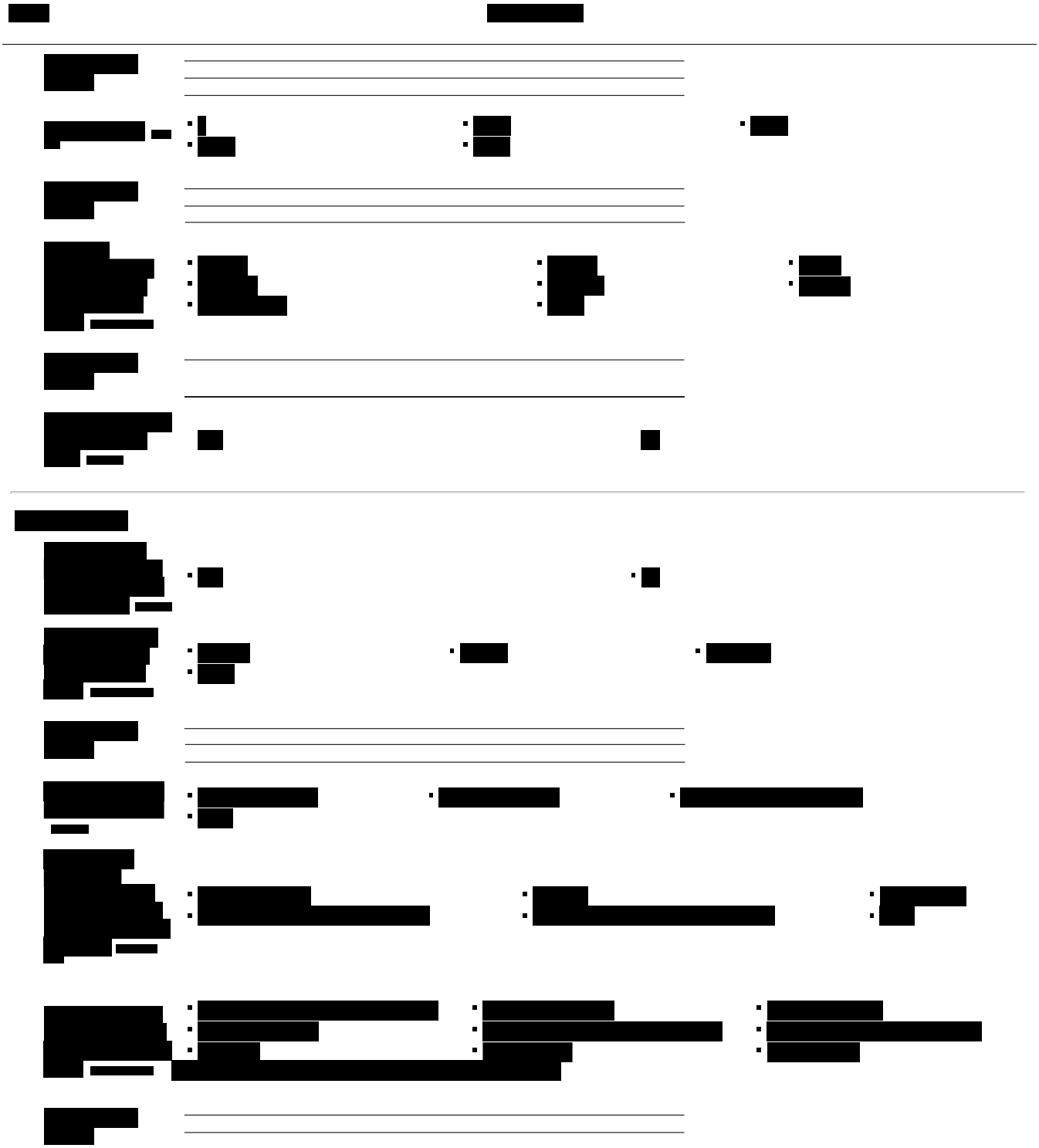












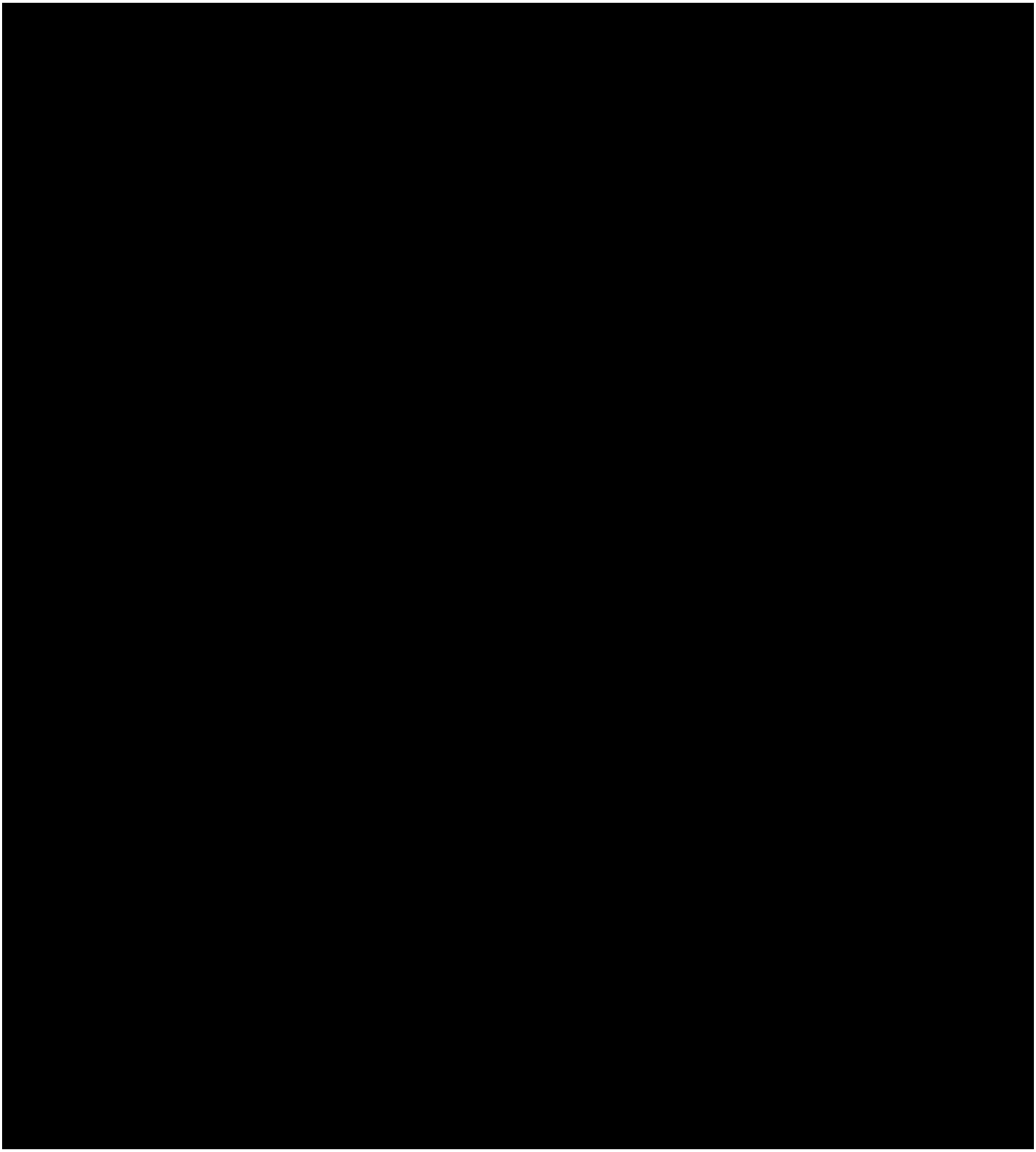
CALLED TO CARE - Robert Rhodes, MD, Chief Executive Officer

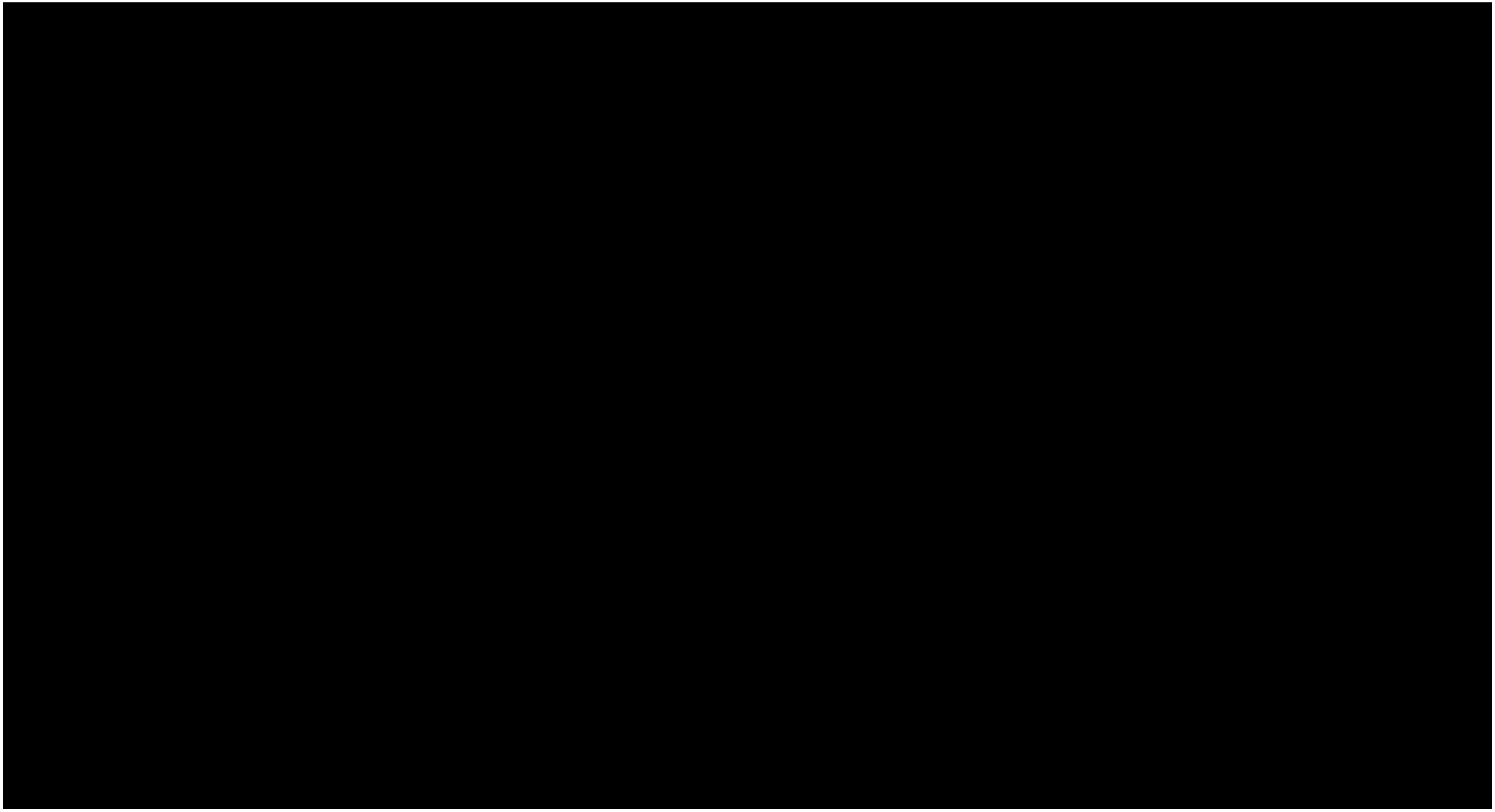
I have lived in Nebraska the last 28 years, and I have worked in Medicaid for 3 years. I am passionate about helping to lead and work with a dedicated team that has great heart for our members. When I was CMO, I took pride in pushing past barriers to help members get the care they needed at the right time and place. One example was getting a young member urgent transportation into a non-participating ophthalmology specialist the next day to help save their vision. Later, we worked to get the provider into our network- so that was a great feeling of a team helping on several levels. Additionally, I am the Founder of Clinic with a Heart, a free health care clinic in Lincoln that serves the homeless, under-insured and uninsured. In that role, I have seen the effects of how social determinants like food insecurity and financial stress can determine someone's health. I want to lead with a servant heart to make a difference for all of those that are more vulnerable.

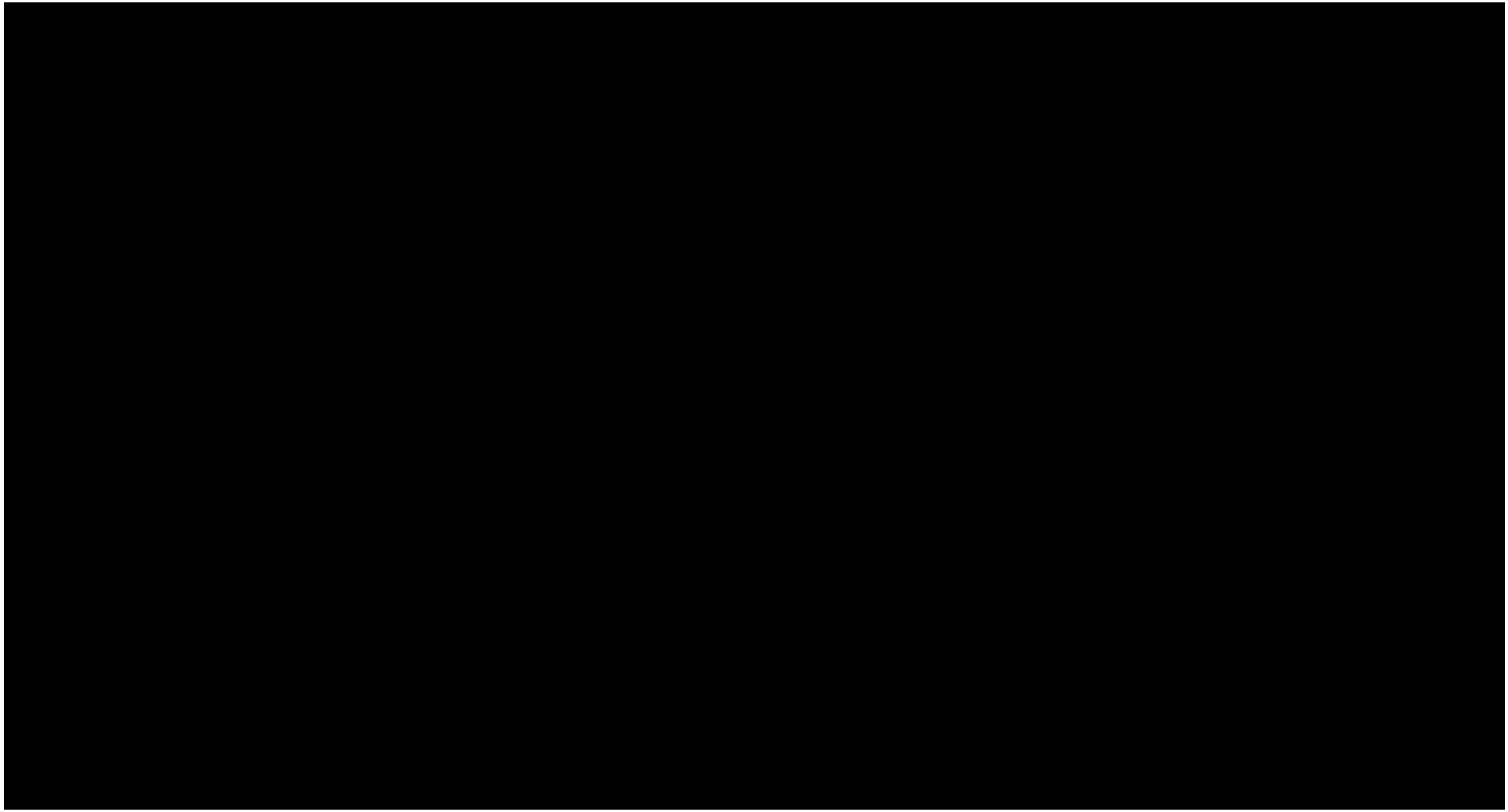
CALLED TO CARE: As a practicing Family Physician in Nebraska for 25 years, I knew Medicaid patients were a special group. Their life stories were amazing and many motivated me or gave me pause to understand ALL that they had endured or were enduring. Sometimes they needed just a little more time, someone to listen and to show them someone cared. I remember that is who I work to help now on a wider scale.

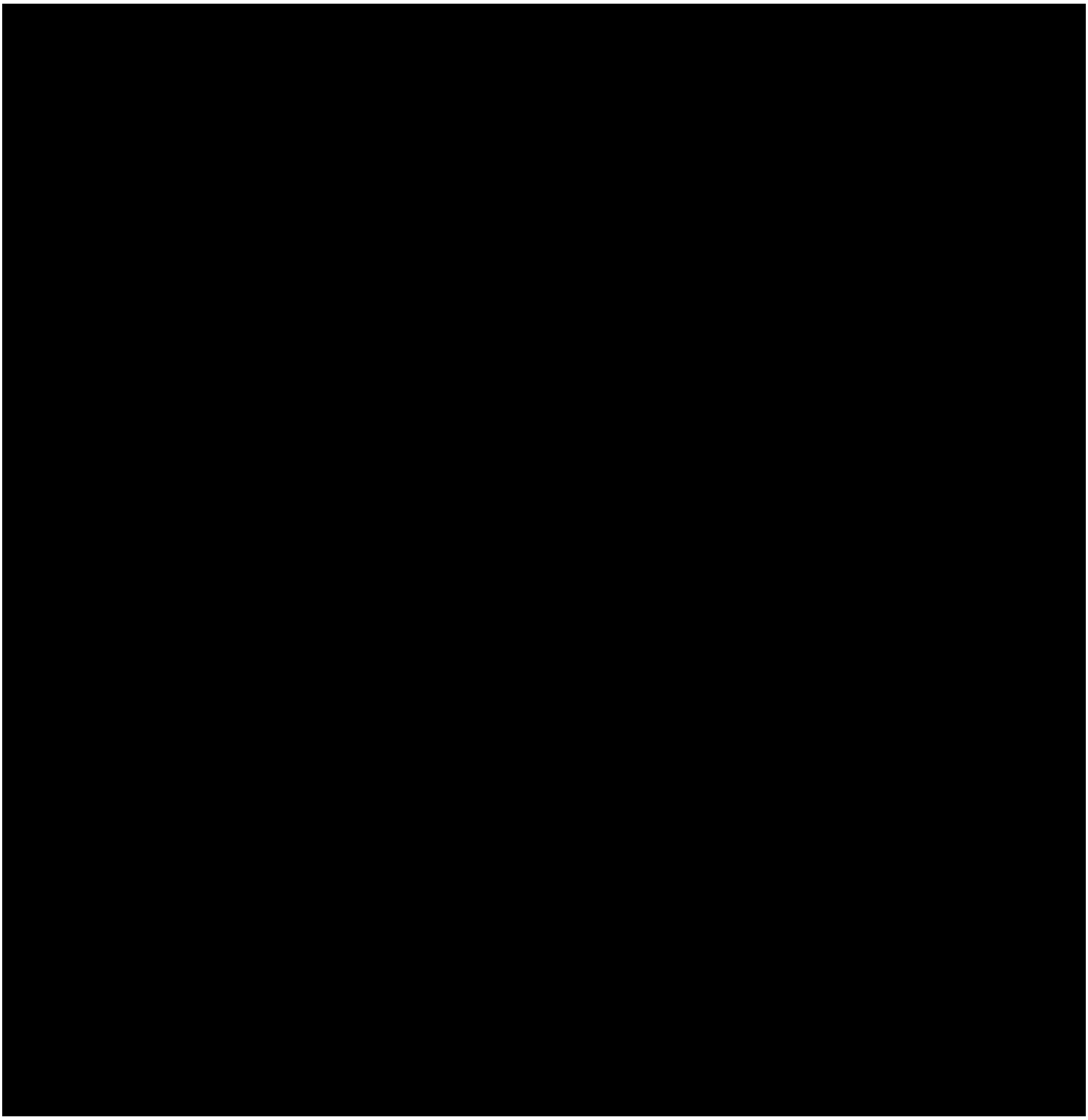
Attachment V.M.74-1: Sample Quality Reports

Healthy Blue









Improving Maternal Wellness

Healthy Blue supports pregnant members and new parents by providing supplies, resources, and community baby showers.

Attachment V.N.82-1: Prior Authorization List

Healthy Blue

[redacted]