Quick Reference Guide

(HPD) Hemoglobin A1c Control for Patients with Diabetes

Admin/ Hybrid

Summary of Changes: The former Comprehensive Diabetes Care (CDC) measure has been separated into three standalone measures:

HBD: Hemoglobin A1c Control for Patients with Diabetes
BPD: Blood Pressure Control for Patients with Diabetes
EED: Eye Exam for Patients with Diabetes

Line of Business: Commercial, Medicaid and Medicare

Measure evaluates percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (< 8.0).
- **Note:** If multiple HbA1c tests were performed in the measurement year, the result from the last test is utilized.

Diabetes Testing

Description	Codes
HbA1c Level Less Than 7.0%	**CPT®/CPT®|CAT-II:** 3044F
HbA1c Level Greater Than or Equal to 7.0% and Less Than 8.0%	**CPT®/CPT®|CAT-II:** 3051F

*Codes subject to change.

To Improve HEDIS Measure:

- Always list the date of service, result and test together. If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result.
- The use of CPT® Category II codes help identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.
- There are resources for obtaining in-home A1c test kits for members that qualify and can be found on our website or by calling Nebraska Total Care.
- Clinics can reduce need for chart review by submitting CPT® Category II codes via supplemental data files.
- Engage Care Management to manage high-risk members and coordinate care.

Quick Reference Guide

(KED) Kidney Health Evaluation for Patients with Diabetes

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year.

Note: Members who received **both** of the following during the measurement year on the same or different dates of service:

- At least one eGFR.
- At least one uACR identified by **both** a quantitative urine albumin test and a urine creatinine test **with** service dates four or less days apart.

Kidney Health Evaluation

Description	Codes
Estimated Glomerular Filtration Rate (eGFR)	**CPT®|CAT II:** 80047, 80048, 80050, 80053, 80069, 82565 **LOINC:** 48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1
Quantitative Urine Albumin Lab Test	**CPT®|CAT II:** 82043 **LOINC:** 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
Urine Creatinine Lab Test	**CPT®|CAT II:** 82570 **LOINC:** 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Urine Albumin Creatinine Ratio Test (uACR)	**LOINC:** 13705-9,14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

*Codes subject to change.

To Improve HEDIS Measure:

- This is an administrative-only measure, so medical record submission is not acceptable.
- Submit claims and encounter data to indicate appropriate testing was completed.
- Educate members on the importance of completing annual labs.

Quick Reference Guide

(SPD) Statin Therapy for Patients with Diabetes

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

Percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- **Received statin therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year.
- **Statin adherence 80 percent:** Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.

Note: The treatment period is defined as the earliest prescription dispensing date in the measurement year for any statin medication of any intensity through the last day of the measurement year.

Statin Therapy Medications

Drug Category	Medications	Medications
High-Intensity Statin Therapy	Amlodipine-atorvastatin 40–80 mg Atorvastatin 40–80 mg Ezetimibe-simvastatin 80 mg	Rosuvastatin 20–40 mg Simvastatin 80 mg
Moderate-Intensity Statin Therapy	Amlodipine-atorvastatin 10–20 mg Atorvastatin 10–20 mg Ezetimibe-simvastatin 20–40 mg Fluvastatin 40–80 mg Lovastatin 40 mg	Pitavastatin 2–4 mg Pravastatin 40–80 mg Rosuvastatin 5–10 mg Simvastatin 20–40 mg
Low-Intensity Statin Therapy	Ezetimibe-simvastatin 10mg Fluvastatin 20 mg Lovastatin 10–20 mg	Pitavastatin 1 mg Pravastatin 10–20 mg Simvastatin 5–10 mg

To Improve HEDIS Measure:

- Encourage patients to enroll in auto-refill programs at their pharmacy.
- Avoid giving samples; only prescriptions with a pharmacy claim are utilized to measure adherence.
- Offer tips to patients such as taking medication at the same time each day, using a pill box, etc.
- Discuss potential side effects and encourage member to contact provider and not stop usage.

Quick Reference Guide

- Educate patients that people with diabetes are two to four times more likely to develop heart disease or stroke. Statins can reduce the chance of developing these risks.

Quick Reference Guide

(AAP) Adults' Access to Preventive/Ambulatory Health Services

Admin

ECDS

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- **Medicaid and Medicare** members who had an ambulatory or preventive care visit during the measurement year,
- **Commercial** members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Proper coding is critical to ensure accurate reporting of the measure, and it may decrease the need for medical record reviews.

Ambulatory Visits

Description	Codes*
CPT®	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99483, 92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
CPT® | CAT II	G0402, G0438, G0439, G0463, G0468, T1015
ICD-10-CM	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1
HCPCS	G0402, G0438, G0439, G0463, T1015, S0620, S0621

*Codes subject to change.

To Improve HEDIS Measure:

- Appropriate coding will ensure the preventative visit is captured through claims submission.
- Contact patients to schedule appointments who have not completed annual preventative visit during the calendar year.

Quick Reference Guide

(ACP) Advance Care Planning

Summary of Changes: First year for this measure.

Admin

Line of Business: Medicare Only.

The percentage of adults 66–80 years of age with advanced illness. They must have a frailty indicator or must be receiving palliative care. Also, those adults who are 81 years of age and older who had advance care planning during the measurement year.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

*Subject to change.

Advance Care Planning

Description	Codes
CPT®	99483, 99497
CPT®|CAT-II	1123F, 1124F, 1157F, 1158F
HCPCS	S0257
ICD-10 CM	Z66

*Subject to change.

To Improve HEDIS Measure:

- Discussion or documentation about members resuscitation, life sustaining treatment and end of life preferences.
- Hospice or using hospice services is a required exclusion.

Quick Reference Guide

(COA) Care for Older Adults

Admin

Summary of Changes: Removed Advanced Care Planning.

Line of Business: Medicare Only

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Medication review
- Functional status assessment
- Pain assessment

Documentation:

- Medication review – A review of all member's medications, including prescription medications, over-the-counter medications, and herbal or supplemental therapies.
- Functional status assessment – Documentation: must include evidence of a complete functional status assessment to include a notation that Activities of Daily Living (ADL) were assessed, cognitive status, sensory ability, and other functional independence.
- Pain assessment – Documentation: must include an assessment for pain (which may include positive or negative findings) or the result of an assessment using a standardized tool, and the date the assessment was completed.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

Care for Older Adults

Description	Codes*
Medication Review Would need both CPT-CAT II codes: (1159F Medication List) & (1160F Medication Review) to meet compliancy	**CPT®:** 90863, 99483, 99605, 99606 **CPT®|CAT-II:** 1159F, 1160F **HCPCS**: G8427
Functional Status Assessment	**CPT®:** 99483 **CPT®|CAT-II**: 1170F HCPCS: G0438, G0439
Pain Assessment	**CPT®|CAT-II:** 1125F, 1126F
Transitional Care Management -7 day & Transitional Care Management- 14 day	**CPT®:** 99495 **CPT®:** 99496

*Codes subject to change

Quick Reference Guide

To Improve HEDIS Measure:

- Ensure the medical record is documented appropriately to report the measures.
- The Medication Review measures requires the medications are listed in the chart plus the review.
- Place an alert within EMR to contact patients as a reminder for upcoming appointment.

Quick Reference Guide

(COL) Colorectal Screening

Admin

ECDS

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicare

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

Colorectal Cancer Screening

Description	Codes*
Colonoscopy	**CPT®:** 44388-44394; 44397, 44401-44408; 45355, 45378-45393; 45398 **HCPCS**: G0105, G0121
CT Colonography	**CPT®:** 74261, 74262, 74263 **LOINC:** 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
FIT-DNA (Cologuard) Test	**CPT®:** 81528 **HCPCS:** G0464 **LOINC:** 77353-1, 77354-9
Flexible Sigmoidoscopy	**CPT®:** 45330-45335, 45338-45342, 45345-45350 **HCPCS:** G0104
FOBT (Fecal Occult Blood Test) Test	**CPT®:** 82270, 82274 **HCPCS:** G0328 **LOINC:** 12503-9,12504-7,14563-1,14564-9,14565-6,2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
Exclusion: Colorectal Cancer	**HCPCS:** G0213- G0215, G0231 **ICD-10 CM**: C18.0 - C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Exclusion: Total Colectomy	**CPT®**: 44150-44153, 44155-44158, 44210-44212 **ICD-10 CM**: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ,0DTE8ZZ

*Codes subject to change

To Improve HEDIS Measure:

- FOBT tests performed in an office or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.

Quick Reference Guide

- Place standing orders for office staff to dispense FOBT or FIT kits to patients needing colorectal screening.
- Reassure the patient who is resistant to having a colonoscopy to perform an at-home stool test (either GFOBT or IFOBT)
- Follow-up with patients to complete the at-home kit and return the specimen for lab results
- Update the patient chart yearly indicating colorectal cancer screening (indicate test performed and the date of lab results)
- Document the patient ileostomies, which entails colon removal and patients with a history of colon cancer

Quick Reference Guide

(TRC) Transitions of Care

Summary of Changes: Physician Assistants can perform medication reconciliations for post discharges.

Admin/ Hybrid

Line of Business: Medicare Only

The percentage of discharges for members 18 years of age and older who had each of the following.

Four rates are reported:

- Notification of Inpatient Admission: Documentation: of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information: Documentation: of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge: Documentation: of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation: of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Transitions of Care

Sample Codes: The codes listed below are not inclusive and do not represent a complete list of codes

Description	Codes
Medication Reconciliation	**CPT®|CAT II:** 99483, 99495, 99496, 1111F
Outpatient Visits	**CPT®|CAT II:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 9934799350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456 **HCPCS:** G0438, G0439, G0463, T1015
Telephone Visits	**CPT®|CAT II:** 98966, 98967, 98968, 99441, 99442, 99443
Telehealth Modifiers	95, GT, 02
Transitional Care Management Services	**CPT®|CAT II:** 99495, 99496

*Codes subject to change.

To Improve HEDIS Measure:

- Proper Documentation: of patient engagement provided within 30 days after discharge is required to meet compliance.
- Use appropriate documentation and correct coding.

Quick Reference Guide

(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription between July 1 of the year prior to the measurement year and June 30 of the measurement year.

A higher rate indicates appropriate treatment (i.e., the proportion for whom antibiotics were *not* prescribed).

If you feel your patient warrants a prescription for antibiotics, include the appropriate diagnosis that would support the use of antibiotics including bacterial infections or chronic conditions.

Appropriate Use of Antibiotics

Description	ICD-10-CM Diagnosis
Chronic Obstructive Pulmonary Disease	J44.0, J44.1, J44.9, J47.1, J47.9
Emphysema	J43.0–J43.2, J43.8, J43.9
Chronic Bronchitis	J41.0, J41.1, J41.8, J42

To Improve HEDIS Measure:

- Instruct patients on the difference between viral and bacterial infections.
- Ensure testing performed to distinguish between viral and bacterial infections are properly coded on claim.
- When patients ask for antibiotics to treat viral infections:
  - Explain that unnecessary antibiotics can be harmful.
  - Emphasize the importance of adequate rest, nutrition and hydration.
  - Provide a prescription for symptom relief instead of an antibiotic, if appropriate.

Quick Reference Guide

(AMR) Asthma Medication Ratio

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicaid

Measure evaluates the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.

Asthma Controller Medications

Description	Prescription	Medication Lists	Route
Antiasthmatic Combinations	Dyphylline-Guaifenesin	Dyphylline Guaifenesin	Oral
Antibody Inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-Interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-Interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-Interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-Interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled Steroid Combinations	Budesonide-Formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled Steroid Combinations	Fluticasone-Salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled Steroid Combinations	Fluticasone-Vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled Steroid Combinations	Formoterol-Mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled Corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled Corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled Corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled Corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled Corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled Corticosteroids	Mometasone	Mometasone Medications List	Inhalation

Quick Reference Guide

Description	Prescription	Medication Lists	Route
Leukotriene Modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene Modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene Modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

*Subject to change.

Asthma Reliever Medications

Description	Prescription	Medication Lists	Route
Short-Acting, Inhaled Beta-2 Agonists	Albuterol	Albuterol Medications List	Inhalation
Short-Acting, Inhaled Beta-2 Agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

*Subject to change.

To Improve HEDIS Measure:

- Members 5 years of age and older with persistent asthma should be prescribed and remain on an asthma controller and be provided with an asthma action plan.
- Ensure members referred for asthma keep their appointment.
- Keep list of member medications current to include medications from other providers.
- Develop asthma action plans with patients and education on reduction of asthma triggers.
- Offer assistance with utilizing inhalers when first prescribed to ensure appropriate usage.
- Ensure the member is not using more rescue medications than preventive medication to control their asthma.
- Report the appropriate diagnosis codes for the member's condition. Include the appropriate codes for diagnosed conditions that may exclude the member from this measure (e.g., emphysema, COPD, obstructive chronic bronchitis, cystic fibrosis, etc.).

Quick Reference Guide

(CWP) Appropriate Testing for Pharyngitis

Summary of Changes: There were no changes to this measure.

Admin

Line of Business: Commercial, Medicaid and Medicare

This measure demonstrates the percentage of episodes for member's 3 years and older who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

A pharyngitis diagnosis can be from an outpatient, telephone, e-visit or emergency department visit between July 1 of the year prior to the measurement year and June 30 of the measurement year.

Testing for Pharyngitis

Description	Codes
Group A Strep Test	**CPT®|CAT-II:** 87070–71, 87081, 87430, 87650–52, 87880 **LOINC:** 11268-0, 17656-0, 17898–8, 18481–2, 31971–5, 49610–9, 5036–9, 60489–2, 626–2, 6557–3, 6558–1, 6559–9, 68954–7, 78012–2
Pharyngitis (can be the only diagnosis from the visit)	**ICD-10:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
Acute Pharyngitis	**ICD-10:** J02.8, J02.9
Acute Tonsillitis	**ICD-10:** J03.00, J03.01, J03.80, J03.90, J03.91
Streptococcal Sore Throat	**ICD-10:** J02.0

*Codes subject to change.

To Improve HEDIS Measure:

- Instruct patients on the difference between viral and bacterial infections.
- Ensure testing performed to distinguish between viral and bacterial infections are properly coded on claim.
- Educate members on comfort measures without antibiotics (e.g., extra fluids and rest).
- If you are treating a member for another condition or illness, document the other diagnosis code on the claim.
- Clinical guidelines recommend a strep test when the only diagnosis is pharyngitis.
- Strep tests can be either a rapid strep test or a lab test.
- Strep testing must be done in conjunction with dispensing of medication.

Quick Reference Guide

(FVA) Flu Vaccinations for Adults Ages 18–64

CAHPS

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicaid

Measure evaluates the percentage of members 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.1H survey was completed.

On an annual basis, the Consumer Assessment of Health Plans Survey (CAHPS) is sent to a group of randomly selected members. Members who respond "Yes" to the question "Have you had either a flu shot or flu spray in the nose since July 1, XXXX?" are counted in the numerator for the calculation of results. Information is collected only thru responses received from the CAHPS survey.

Quick Reference Guide

(PCE) Pharmacotherapy Management of COPD Exacerbation

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

Measure evaluates percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Systemic Corticosteroid Medications

Description	Prescription	Prescription
Glucocorticoids	Cortisone-acetate Dexamethasone Hydrocortisone	Methylprednisolone Prednisolone Prednisone

*Subject to change.

Bronchodilator Medications

Description	Prescription	Prescription
Anticholinergic Agents	Aclidinium-bromide Ipratropium	Tiotropium Umeclidinium
Beta 2-Agonists	Albuterol Arformoterol Formoterol Indacaterol	Levalbuterol Metaproterenol Olodaterol Salmeterol
Bronchodilator Combinations	Albuterol-ipratropium Budesomide-formoterol Fluticasone-salmetrol Fluticasone-vilanterol Fluticasone-furoate-umeclidinium-vilanterol	Formoterol-aclidinium Formoterol-glycopyrrolate Formoterol-mometasone Glycopyrrolate-indacaterol Olodaterol-tiotropium Umeclidinium-vilanterol

Quick Reference Guide

*Subject to change.

To Improve HEDIS Measure:

- Schedule a follow-up appointment within 7–14 days of discharge and ensure your patient has the appropriate medications.
- Have members demonstrate use of inhalers to ensure medication administration is appropriately given.

Quick Reference Guide

(URI) Appropriate Treatment for Upper Respiratory Infection

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial, Medicaid and Medicare

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. Note:

- This measure is reported per episode and not per member.
- Measurement timeframe begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
- A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.
- Note: If ordering antibiotics, list all competing or comorbid diagnosis codes on claim when submitting e.g., acute pharyngitis, acute sinusitis, otitis media, emphysema, COPD, chronic bronchitis.

Identify Upper Respiratory Infection

ICD-10 Codes to Identify URI	J00, J06.0, J06.9

To Improve HEDIS Measure:

- Instruct patients on the difference between viral and bacterial infections.
- Educate members on comfort measures without antibiotics (e.g., extra fluids and rest).
- Utilize the Viral Treatment Plan for Symptom Relief pad to help patients with talking points and for educating on instructions. Contact your Clinical Quality Consultant to obtain this resource.
- Discuss facts, including:
  - A majority of URIs are caused by viruses, not bacteria.
  - Antibiotics will not help a patient get better or feel better when diagnosed with a viral infection.
  - Taking antibiotics when not indicated could cause more harm than good.

Quick Reference Guide

(LBP) Use of Imaging Studies for Low Back Pain

Summary of Changes: Age range expanded to 75 years.

Admin

Line of Business: Commercial, Medicaid and Medicare

Percentage of members ages 18–75 with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Note: This measure is reported as an inverted rate and a higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

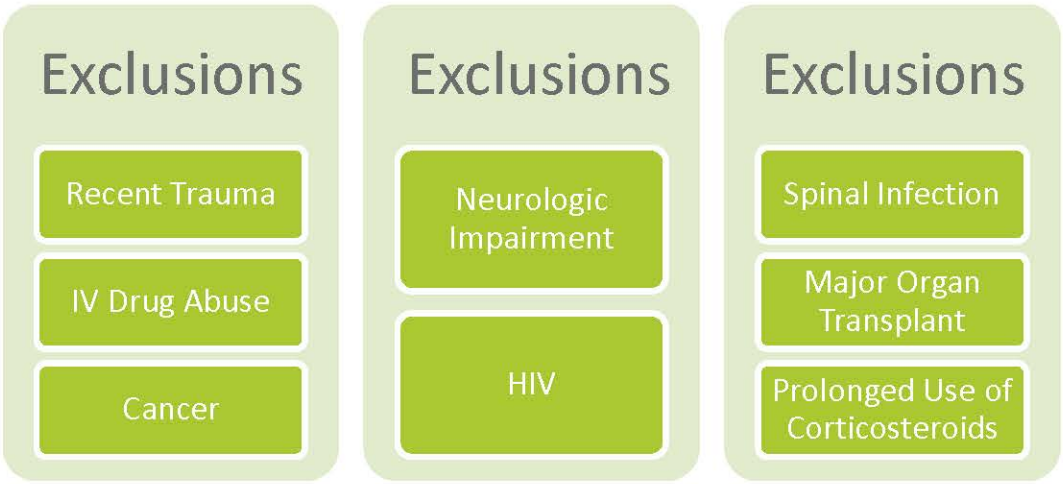
Imaging Studies

Description	Codes
CPT®|CAT-II	72020, 72052, 72100, 72110, 72114, 72120, 72131–33, 72141–42, 72146–49, 72156, 72158, 72200, 72202, 72220

*Codes subject to change.

To Improve HEDIS Measure:

- Avoid ordering diagnostic studies in the first 6 weeks of new-onset back pain in the absence of red flags (e.g., cancer, recent trauma, neurologic impairment, or IV drug abuse).
- Provide patient education on comfort measures such as pain relief, stretching exercises, and activity level.
- Look for other reasons for visits for low back pain (e.g., depression, anxiety, narcotic dependency, psychosocial stressors).
- Use of correct exclusion codes where necessary.



Quick Reference Guide

(MSC) Medical Assistance with Smoking and Tobacco Use Cessation

Summary of Changes: There were no changes to this measure.

CAHPS

Line of Business: Commercial, Medicaid and Medicare

On an annual basis, the Consumer Assessment of Health Plans Survey (CAHPS) is sent to a group of randomly selected members. Rates are based upon responses received from those who completed the survey.

Measure assesses members ages 18 and older who were current smokers or tobacco users to determine if they were provided medical assistance with smoking and tobacco use cessation. Three rates are calculated:

- Advised to quit during the measurement year.
- Recommended cessation medications during the measurement year.
- Discussed or were provided cessation methods or strategies during the measurement year.

Quick Reference Guide

(PCR) Plan All-Cause Readmissions

Summary of Changes: There were no changes to this measure.

Admin

Line of Business: Commercial, Medicaid and Medicare

For members ages 18–64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Note: *A lower rate indicates a better score for this measure.*

To Improve HEDIS Measure:

- The denominator for this measure is based on discharges and not members specifically.
- Ensure all clinical support systems are in place prior to discharge.
- Follow-up with members within one week of their discharge.
- Ensure members filled their new prescriptions post discharge.
- Consider case management for members with chronic conditions, multiple co-morbidities and a history of frequent hospitalizations.
- Ask patients about barriers or issues that might have contributed to patients' hospitalization. Discuss benefits available from the health plan that may prevent future hospitalizations.

Quick Reference Guide

(BCS) Breast Cancer Screening

Admin

ECDS

Summary of Changes: Unilateral mastectomy and bilateral modifier must be from same procedure to be considered an optional exclusion.

Line of Business: Commercial, Medicaid, Medicare

Measure evaluates the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer anytime on or between October 1 two years prior to the measurement year through December 31 of the measurement year.

Mammography

Description	Codes
CPT®|CAT-II	77061–77063,77065–77067
HCPCS	G0202, G0204, G0206
ICD-10 (bilateral mastectomy)	Z90.13
LOINC	24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0

*Codes subject to change.

To Improve HEDIS Measure:

- Ensure that an order or prescription for a mammogram is given at well-woman exams for women 50–74 years old.
- Consider adopting a Standing Order and/or automated referrals for mammography for eligible women.
- Ensure proper documentation of mammography and exclusions in the patient's medical record:
  - Provide results or findings to indicate test was performed.
  - Document screening in the "medical history" section of the record and update the section annually/biannually.

Quick Reference Guide

- Visit our NebraskaTotalCare.com for rewards for healthy behaviors and preventive screenings that may be available to members.
- It's important to submit the appropriate ICD-10 diagnosis code that reflects a member's ***history of bilateral mastectomy, Z90.13***. Code should be submitted with the initial visit claim and annually thereafter.

Quick Reference Guide

(CCS) Cervical Cancer Screening

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicaid

Admin/ Hybrid

This measure demonstrates the percentage of women 21–64 years of age who were screened for cervical cancer using **any** of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years or,
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Cervical Cancer Screening

Description	Codes
Cervical Cytology (20–64)	**CPT®|CAT-II:** 88141 - 88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
High Risk HPV Tests (30–64)	**CPT®|CAT-II:** 87624, 87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
Absence of Cervix	**ICD-10:** Q51.5, Z90.710, Z90.712

*Codes subject to change.

To Improve HEDIS Measure:

- Use ICD-10 Q51.5, Z90.710 or Z90.712 to indicate the exclusion (acquired absence of cervix/uterus).
- Medical record must have cervical cytology test results and hrHPV results documented, even if member self-reports being previously screened by another provider.

Quick Reference Guide

(CHL) Chlamydia Screening in Women

Admin

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicaid

Measure evaluates the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Sexually active is defined as any member who:

- Had a pregnancy test.
- Had any other STD testing completed.
- Had a prescription filled for contraceptives.

Chlamydia Screening Test

Description	Codes
CPT®|CAT-II	87110, 87270, 87320, 87490–87492, 87810
LOINC	14463-4, 14464-2, 14467-5, 14474-1,14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7

*Codes subject to change.

To Improve HEDIS Measure:

- Ensure females 16–24 years of age receive appropriate screening for chlamydia each year.
- Chlamydia infections often have no symptoms so routine screening when at risk is important. The CDC recommends non-invasive nucleic acid amplification test or NAAT for chlamydia screening. This can be completed through a urine test. Use CPT® code 87491.
- Add Chlamydia screening as a standard lab for women 16–24 years old. Use well-child exams and well-women exams for this purpose.

Quick Reference Guide

(PPC) Prenatal and Postpartum Care

Admin/ Hybrid

Summary of Changes: There were no changes to this measure.

Line of Business: Commercial and Medicaid

Measure evaluates percentage of deliveries of live births on or between October 8 of the year prior and October 7 of the measurement year. For these women, the measure assesses the following:

- **Timeliness of Prenatal Care**: percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- **Postpartum Care:** percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Prenatal and Postpartum Care

Description	Codes
Prenatal Visits	**CPT®|CAT-II:** 99201–99205, 99211–99215, 99241–99245, 99483 HCPCS: G0463, T1015
Prenatal Bundled Services	**CPT®|CAT-II:** 59400, 59425, 59426, 59510, 59610, 59618 **HCPCS:** H1005
Stand Alone Prenatal Visits	**CPT®|CAT-II:** 99500, 0500F, 0501F, 0502F HCPCS: H1000, H1001, H1002, H1003, H1004
Cervical Cytology	**CPT®|CAT-II:** 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
Postpartum Visits	**CPT®|CAT-II** 57170, 58300, 59430, 99501, 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Postpartum Bundled Services	**CPT®|CAT-II**: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Telephone Visits	**CPT®|CAT-II:** 98966–98968, 99441–99443

*Codes subject to change.

Quick Reference Guide

To Improve HEDIS Measure:

Prenatal Care:

- Ensure that a Notification of Pregnancy form has been sent to Nebraska Total Care.
- Encourage patient to attend all scheduled prenatal visits.
- Ensure that an antepartum flow sheet is completed at each visit.

Postpartum Care: Ensure postpartum visit is completed 7–84 days after delivery and includes one of the following:

- Pelvic exam.
- Evaluation of weight, BP, breast, and abdomen or notation of breastfeeding.
- Notation of postpartum (PP) care:
  - PP check, postpartum care, 6-week check, preprinted form.
- Perineal or Cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder or pre-existing mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Quick Reference Guide

(PRS-E) Prenatal Immunization Status

ECDS

Summary of Changes: New measure. Reported by Electronic Clinical Data Systems (ECDS).

Line of Business: Commercial and Medicaid

Percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

Three rates are reported:

- Immunization Status: Influenza
  - Members who delivered and received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date.
- Immunization Status: Tdap
  - Members who delivered and received at least one Tdap vaccine during the pregnancy (including on the delivery date), or
  - Members who delivered had any of the following:
    - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
    - Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
- Immunization Status: Combination
  - Deliveries that met criteria for both Influenza and Tdap, noted above.

Prenatal Immunization Status

Description	Codes
Gestation Weeks (37–42)	**ICD-10:** Z3A.37-42, Z3A49 **SNOMED:** 43697006, 13798002, 80487005, 46230007, 63503002, 36428009

*Codes subject to change.

To Improve HEDIS Measure:

- If you do not have flu vaccines available, refer the patient to another provider such as a pharmacy or public health agency.
- Educate mother on how the flu vaccine will protect both her and her baby.
- Educate mother on how passive immunity the maternal immunization provides will pass on to their newborns.
  - It is recommended that the Tdap vaccine be given in the third trimester.

Quick Reference Guide

  - Babies whose mothers had the Tdap vaccine during pregnancy are better protected against whooping cough during the first two months of life.
- Per Advisory Committee on Immunization Practices (ACIP) guidance, Tdap in pregnancy is given with every pregnancy; preferably the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap.

RFP 112209 O3

B. Technical Approach

V.K Subcontracting Requirements

V.K Subcontracting Requirements

49. For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following:

- *The date the company was formed, established or created.*
- *Ownership structure (whether public, partnership, subsidiary, or specified other).*
- *Organizational chart.*
- *Total number of employees.*
- *Whether the subcontractor is currently providing services for the Bidder in other states and the subcontractor's location.*

Page Limit: 1 page per subcontracting organization (Per Addendum 1, Q&A #114 organizational chart can be submitted outside of the 1 page subcontracting limit)

Nebraska Total Care's Proposed Subcontractor Details

Nebraska Total Care carefully selects our Subcontractors based on proven experience to support our delivery of high-quality person-centered health care services to Heritage Health populations. We will continue to meet and exceed the requirements of V.K Subcontracting Requirements in our Nebraska operations and will be wholly accountable for any functional and responsibility we delegate to Subcontractors and continue to oversee Subcontractor performance in accordance with 42 CFR § 438.230.

Nebraska Total Care will submit a finalized list of Subcontractors, as well as their respective contracts, to MLTC for review and approval at least 120 calendar days prior to the anticipated implementation date of the Subcontract. We do not and will not subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7) or is otherwise barred from participation in the Medicaid or Medicare programs.

Nebraska Total Care is proposing Subcontractors in accordance with RFP 112209 O3 Addendum 1, Questions and Answers, #64, as well as Addendum 3, Questions and Answers Round 2, #17. This list is specific to entities Nebraska Total Care intends to contract with to perform a portion of the work awarded by MLTC and does not include vendors or entities who perform ancillary functions for Nebraska Total Care.

The following **Tables 49.A** through **49.N** are organized by affiliate proposed Subcontractors followed by non-affiliate proposed Subcontractors. Each table details the Subcontractor's role in this project, their corporate background, size, resources, and details addressing the date the organization was established, its ownership structure, total number of employees, whether it currently provides these services to Nebraska Total Care, and its headquarters location, in accordance with Addendum 1, Questions and Answers, #118. For Subcontractor organization charts, see **Attachment B.49**.

Nebraska Total Care Affiliate Proposed Subcontractors

Table 49.A Centene Management Company (CMC)	
Organization's Role	CMC will support Nebraska Total Care by providing Information System Support, Claims Processing and Administration, Program Integrity, Provider Data Management, Contact Center/Workforce Management, Human Resources Support, Finance Systems, Utilization Management, Disease Management, Nurse Advice Line, Translation and Interpretation Services, Pharmacy Administrative and Care Management Services.
Corporate Background, Size, and Resources	CMC serves as the management company for Centene health plans and provides the majority of administrative services required for Nebraska Total Care. CMC provides similar services to Centene-owned Medicaid, CHIP, and Medicare health plans and serves similar Medicaid managed care plans in 29 States. CMC also serves Marketplace programs in 22 States; Medicare programs in all 50 States, and subsidiary organizations supporting government health care programs nationwide.
Date Established	1996
Ownership Structure	CMC is a limited liability company and is 100% owned by Centene Corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	72,500
Currently Providing Services and Location	CMC currently provides these services to Nebraska Total Care and affiliate health plans. CMC is headquartered in St. Louis, MO.

Table 49.B Envolve Dental, Inc.	
Organization's Role	Envolve Dental,Inc. will support Nebraska Total Care by providing Dental Benefits Management, Provider Calls, Network Management, Network Management, Credentialing/Re-Credentialing, Claims Adjudication, Provider Claims Appeals Level 1, Quality Improvement, Encounter Management, and Provider Grievances services.
Corporate Background, Size, and Resources	Envolve Dental administers dental benefits for Medicaid, Medicare, and Health Insurance Marketplace (Marketplace) products in 30 States. Envolve holds NCQA accreditation in credentialing and utilization management.
Date Established	2013
Ownership Structure	Envolve Dental, Inc. is a for-profit corporation and wholly-owned subsidiary of Envolve Benefit Options, which is 100% owned by Envolve Holdings, Inc., which is in turn wholly-owned by Centene Corporation, a for-profit corporation that is publicly owned and traded on the NYSE under the symbol "CNC."
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	279
Currently Providing Services and Location	Envolve Dental currently provides these services to Nebraska Total Care and affiliate health plans. Envolve Dental is headquartered in Tampa, FL.

Table 49.C Envolve Vision, Inc.	
Organization's Role	Envolve Vision, Inc. will support Nebraska Total Care by providing Vision Benefits Management - Routine Visions Services, Provider Calls, Network Management, Credentialing/Recredentialing, Claims Adjudication, Provider Claims Appeals Level 1, Quality Improvement, Encounter Management, and Provider Grievances services.
Corporate Background, Size, and Resources	Envolve Vision has provided capitated vision administration services for over 30 years, and to Medicaid populations for over 20 years. Envolve Vision currently provides benefits to 12 million Foster Care, TANF, ABD, Dual Eligible, Medicare, CHIP, and commercial members in 32 States and Puerto Rico. Envolve holds NCQA accreditation in credentialing and utilization management.
Date Established	2006
Ownership Structure	Envolve Vision, Inc. is a for-profit corporation and wholly-owned subsidiary of Envolve Benefit Options, which is 100% owned by Envolve Holdings, Inc., which is in turn wholly-owned by Centene Corporation, a for-profit corporation that is publicly owned and traded on the NYSE under the symbol "CNC."
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	353
Currently Providing Services and Location	Envolve Vision currently provides these services to Nebraska Total Care and affiliate health plans. Envolve Vision is headquartered in Rocky Mount, NC.

Table 49.D National Imaging Associates (NIA)	
Organization's Role	NIA will support Nebraska Total Care by providing Utilization Management - Radiology and Cardiac, and Provider Calls services.
Corporate Background, Size, and Resources	Founded in 1995, NIA pioneered the radiology benefits management industry. With long-standing experience grounded in clinical research, innovative technology, and proven results, NIA has become a proven leader in providing clinically driven specialty solutions to effectively manage quality and cost.
Date Established	1995
Ownership Structure	NIA is a wholly-owned subsidiary of Magellan Healthcare, Inc., which is a wholly-owned subsidiary of Centene Corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	743

Table 49.D National Imaging Associates (NIA)	
Currently Providing Services and Location	NIA currently provides these services to Nebraska Total Care and affiliate health plans. NIA is headquartered in Phoenix, AZ.

Nebraska Total Care Non-Affiliate Proposed Subcontractors

Table 49.E Best Foot Forward	
Organization's Role	Best Foot Forward will support Nebraska Total Care by providing Member Outreach - Outreach to Unable to Contact members: Pregnant, Homeless and High Priority to perform Notification of Pregnancy, Health Risk Screening, and Social Determinants of Health mini screening.
Corporate Background, Size, and Resources	Best Foot Forward, a certified minority-owned and HITRUST-certified business, is headquartered in South Florida, with offices in Illinois, Indiana, Ohio, and Pennsylvania. Best Foot Forward's mission is to provide integrated programs using insight-driven solutions that focus on delivering a clear process to connect, communicate, and assist managed care members and plan providers. With years of experience working with some of the country's top health insurance providers, Best Foot Forward is uniquely qualified to fully support Medicare, Medicaid, and commercial client's needs. Best Foot Forward has developed an approach specially customized for each health plan's needs. Our proven location tools use effective and personal phone-based strategies to not only locate and identify these hard-to-reach individuals, but once connected, can engage the member in a health gap reduction activity specified by the plan.
Date Established	May 1, 2009
Ownership Structure	Best Foot Forward is a private S corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	100+
Currently Providing Services and Location	Based on our affiliates' success, Best Foot Forward will begin providing these services to Nebraska Total Care before the new contract start date. Best Foot Forward is headquartered in Plantation, FL.

Table 49.F CaremarkPCS Health (CVS)	
Organization's Role	CaremarkPCS Health (CVS) will support Nebraska Total Care by providing Pharmacy Benefits Management services.
Corporate Background, Size, and Resources	CVS Health is the largest pharmacy health care provider in the United States with integrated offerings across the entire spectrum of pharmacy care. They are a leading PBM that provides specialty/biotech services, disease management, and other health services related to prescription benefit management. Since first providing PBM services in 1969, CVS Health has grown to become a national leader in providing programs currently serving more than 2,000 clients and their members across all 50 States, Puerto Rico, and the Virgin Islands. Through mail, retail, and specialty distribution channels, they administer programs for a diverse client base, including corporations, managed care organizations, insurance companies, government entities, unions, third-party administrators, and other organizations that pay for health care products and services.
Date Established	May 8, 1963
Ownership Structure	CaremarkPCS Health, L.L.C. ("CVS Health") is a wholly-owned direct subsidiary of CaremarkPCS, L.L.C., a subsidiary of Caremark Rx, L.L.C., whose ultimate parent company is CVS Health Corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	300,000
Currently Providing Services and Location	CVS currently provides these services to Nebraska Total Care and affiliate health plans. CVS is headquartered in Woonsocket, RI.

Table 49.G Change Healthcare	
Organization's Role	Change Healthcare will support Nebraska Total Care by providing Service Verification of Benefits services.
Corporate Background, Size, and Resources	Change Healthcare, as McKesson Health Solutions, has been providing claims auditing solutions for nearly 40 years. ClaimsXten™ is our advanced claim editing solution that applies complex payment and medical policies as well as unique provider contract terms to the adjudication process. Recognized as the industry leader in this market, Change Healthcare represents nearly 80 health plans representing 185+ million covered lives. These health plans comprise 13 out of the 15 largest health plans in the US, numerous multi-state and regional BlueCross Blue Shield plans, as well as Managed Medicaid and Medicare Advantage organizations. In addition, our tools are used to support 13 State Medicaid programs. ClaimsXten is the primary code editing solution used by our customers across all 50 US States and Puerto Rico. It is also used to edit claims for 16 million fee-for-service and Managed Medicaid lives.
Date Established	2008
Ownership Structure	Change Healthcare is a public corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	14,000
Currently Providing Services and Location	Change Healthcare currently provides these services to Nebraska Total Care and affiliate health plans. Change Healthcare is headquartered in Murray, UT.

Table 49.H Community Pharmacy Enhanced Services Network (CPESN)/Nebraska Enhances Services Pharmacies (NESP)	
Organization's Role	CPESN's local affiliate NESP will support Nebraska Total Care by providing Medication Management services.
Corporate Background, Size, and Resources	CPESN® USA is a clinically integrated, nationwide organization of local networks whose participating pharmacies are accountable for the care they provide to patients. CPESN USA harnesses the value of individual, community-based pharmacies that each provide enhanced services into a collaborative organization that delivers evidence-based care and services to thousands of patients. As part of a broader patient care team, CPESN pharmacies integrate with the other providers to coordinate medical treatment. Care Coordination leads to better medication adherence, higher patient satisfaction, and lower health care costs. CPESN® pharmacy provider networks are now in 45 States across America. NESP, an affiliate of CPESN, enables the provision of patient-centered services by the local community pharmacies through a participation network of nearly 60 Nebraska pharmacies that shares sustainable practice approaches and advocates for business strategies consistent with supporting these services.
Date Established	2016
Ownership Structure	CPESN USA is a limited liability company with two non-profit member owners: Community Care of North Carolina (50%) and the National Community Pharmacists Association (50%).
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	33 CPESN corporate employees. NESP is governed through volunteer officers and biweekly meetings that all member pharmacies are invited to attend.
Currently Providing Services and Location	CPESN currently provides these services to Nebraska Total Care and affiliate health plans. CPESN is headquartered in Cary, NC.

Table 49.I Cotiviti	
Organization's Role	Cotiviti will support Nebraska Total Care by providing Prepay Claims Audits, Postpay Claims Audits, COB Disallowance, and Data Mining services.
Corporate Background, Size, and Resources	Cotiviti has been providing payment integrity solutions for more than 20 years. We work with more than 90 health plans, including 24 of the top 25 and 92 percent of Blues plans.
Date Established	1979

Table 49.I Cotiviti	
Ownership Structure	Cotiviti, Inc. is a private corporation.
Organizational Chart	*Please see* ***Attachment B.49***
Total Number of Employees	7,000
Currently Providing Services and Location	Cotiviti currently provides these services to Nebraska Total Care and affiliate health plans. Cotiviti is headquartered in South Jordan, UT.

Table 49.J MCMC	
Organization's Role	MCMC will support Nebraska Total Care by providing Independent Medical Reviews.
Corporate Background, Size, and Resources	For more than thirty years MCMC has offered a variety of independent clinical review services to the health, pharmacy, and disability markets. MCMC completes over 100,000 reviews each year for more than 400 clients, including almost all the nation's largest Health Plans, PBMs, Disability Carriers, TPAs, UR companies, Self-Insured Employers, Taft-Hartley Plans, and Government Organizations.
Date Established	1984
Ownership Structure	MCMC Services, LLC is a limited liability company.
Organizational Chart	*Please see* ***Attachment B.49***
Total Number of Employees	84
Currently Providing Services and Location	MCMC currently provides these services to Nebraska Total Care and affiliate health plans. MCMC is headquartered in Quincy, MA.

Table 49.K MTM	
Organization's Role	MTM will support Nebraska Total Care by providing Non-Emergency Medical Transportation, Member Calls, Provider Calls, Claims Adjudication, and Network Management services.
Corporate Background, Size, and Resources	As one of the nation's most experienced and qualified non-emergency medical transportation (NEMT) brokers, MTM quickly set industry standards and is now one of the largest and most established NEMT brokers, scheduling more than 13 million trips for 10 million members nationwide while handling four million calls every year. MTM remains a family owned and operated, privately held "S" corporation. Additionally, MTM is a Woman-Owned Business Enterprise (WBE) certified by the Women's Business Enterprise National Council, operates in 29 States and the District of Columbia, and maintains call centers and offices across the United States.
Date Established	June 1995
Ownership Structure	Medical Transportation Management, Inc. is a Private S Corporation.
Organizational Chart	*Please see* ***Attachment B.49***
Total Number of Employees	1,105
Currently Providing Services and Location	MTM currently provides these services to Nebraska Total Care and affiliate health plans. MTM is headquartered in Lake Saint Louis, MO.

Table 49.L Optum	
Organization's Role	Optum will support Nebraska Total Care by providing Data Mining services.
Corporate Background, Size, and Resources	Optum provides data, analytics, research, consulting, technology, and managed services solutions to hospitals, physicians, health plans, governments, and life sciences companies. This business helps customers reduce administrative costs, meet compliance mandates, improve clinical performance and transform operations.
Date Established	1996
Ownership Structure	Optum, Inc., is a 100% wholly-owned subsidiary of UnitedHealth Group, Inc.
Organizational Chart	*Please see* ***Attachment B.49***
Total Number of Employees	6,500
Currently Providing Services	Optum currently provides these services to Nebraska Total Care and affiliate health

Table 49.L Optum	
and Location	plans. Optum is headquartered in Eden Prairie, MN.

Table 49.M Performant	
Organization's Role	Performant will support Nebraska Total Care by providing Post Pay Claims Audit services.
Corporate Background, Size, and Resources	Performant has been providing claim audit, COB/TPL, and Health care claims recovery services for over 12 years. Performant's payment integrity clients include the largest national payers and a host of regional and local health plans. Performant provides services for Medicare Advantage, Commercial, and Managed Medicaid lines of business. In addition to our commercial work, Performant the sole RAC Auditor for Region 5 and one of only three regional CMS RAC auditors and is the sole national CMS contractor operating the Medicare Secondary Payer, Commercial Repayment Center.
Date Established	1976
Ownership Structure	Performant Healthcare Solutions (Performant) is a wholly-owned subsidiary of Performant Financial Corporation.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	773
Currently Providing Services and Location	Performant currently provides these services to Nebraska Total Care and affiliate health plans. Performant is headquartered in Livermore, CA.

Table 49.N Rawlings	
Organization's Role	Rawlings will support Nebraska Total Care by providing Subrogation, Worker's Compensation Subrogation, Mass Tort, COB Disallowance, and COB Clinical Trials.
Corporate Background, Size, and Resources	Rawlings was founded in 1977 to offer legal services to insurance companies. In 1982, recognizing the need for specialized recovery services for the health care industry, Rawlings created outsourcing programs specifically dedicated to medical and pharmacy claims recovery. Today, Rawlings is focused exclusively on recovery services for our health insurance and health plan clients. Through this focus and our commitment to providing outstanding responsiveness and flexibility to our clients, we have grown into the largest provider of these services, in the industry. Rawlings has partnered with Centene since 2014 and began providing services related to Nebraska Total Care in 2017.
Date Established	1977
Ownership Structure	Rawlings, LLC is a limited liability company.
Organizational Chart	*Please see **Attachment B.49***
Total Number of Employees	1,466
Currently Providing Services and Location	Rawlings currently provides these services to Nebraska Total Care and affiliate health plans. Rawlings is headquartered in La Grange, KY.

50. For subcontracted roles included in the proposal, describe the Bidder's process for monitoring and evaluating performance and compliance, including but not limited to how the Bidder will:

• 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 that 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.
Page Limit: 8

Nebraska Total Care's Process to Monitor and Evaluate Subcontractor Performance and Compliance

Nebraska Total Care understands that we are ultimately responsible for all products, services, and obligations in the Scope of Work (SOW), including SOW Section V.K and as required by 42 CFR 438.230, regardless of whether we enter into a subcontract to delegate performance of any of the Contract requirements. We do not subcontract with any entity excluded from participation in Medicaid or Medicare or entities with suspensions/debarments. Our Subcontractor Agreements include provisions to ensure the successful fulfillment of all contractual obligations, including performance guarantees and standards for financial stability. Nebraska Total Care applies a rigorous process for assessing and monitoring Subcontractor service performance under our contracts.

Members and providers experience the same quality services from Subcontractors as Nebraska Total Care. Our Subcontractors, including pharmacy, dental, vision, and non-emergency medical transportation (NEMT) benefit managers, use secure and compliant communication platforms and resources such as reporting applications to provide prompt and effective member services. Our parent company maintains long-standing contractual arrangements with our national Subcontractors which allows us to leverage best practices from other markets, develop innovative strategies applicable to Nebraska from other States, and adjust to meet changing requirements or new program implementations.

All Subcontractors are fully vetted in our comprehensive ***Third-Party Risk Management (TPRM) Program*** and Subcontractor Assessment Process detailed below. Our written Subcontractor Agreements clearly define performance metrics, guarantees, and reporting requirements, which include:

- Delineation of responsibilities for Nebraska Total Care and the Subcontractor
- Specific delegated activities and business and regulatory reporting requirements
- Explicit statement of enforcement, consequences, and corrective action process if a Subcontractor fails to meet the contractual terms, up to and including revocation of the delegation agreement

Nebraska Total Care will submit all Subcontracts for the provision of any services under this RFP to MLTC for preliminary review and approval a minimum of 120 calendar days before implementation. Nebraska Total Care understands that MLTC may approve or disapprove all Subcontracts entered into for services under this RFP.

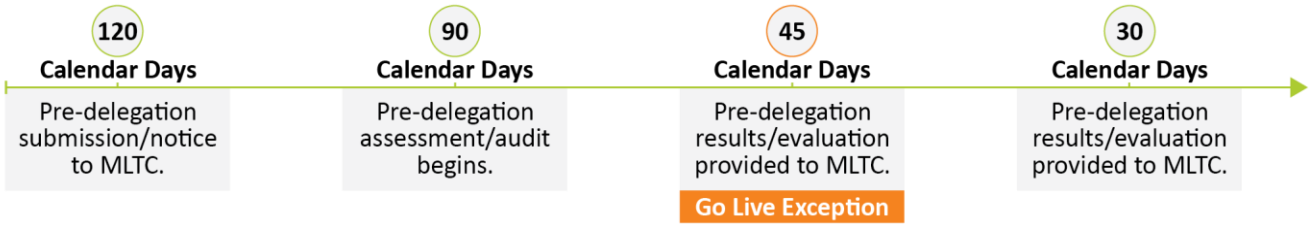
Pre-Delegation Subcontractor Assessment Process. Nebraska Total Care's Compliance team conducts a pre-delegation audit of potential Subcontractors a minimum of 90 calendar days before contracting, and additional audits throughout the life of the contract. We assign a risk level to each Subcontractor using our TPRM Program Inherent Risk Questionnaire - Subcontractor Intake Form and Pre-Delegation Request Form. TPRM risk levels are based on Subcontractor experience with other entities, previous audit/metric results, security controls, demonstrated abilities, and readiness. The risk level determines the frequency and structure of our oversight activities. Comprehensive audits include a thorough review to evaluate the Subcontractor's ability to perform delegated services and ensure compliance with all contractual requirements. Depending on the scope of work delegated, this audit may include but is not limited to:

- Accreditation and financial stability
- Administration, operations, and technology
- Claims and encounter processing
- Member and Provider complaints, grievances, and appeals
- Provider contracting and credentialing
- Network accessibility and availability
- Compliance program and compliance training
- Quality, utilization, and disease management programs

We provide the results of our pre-delegation reviews to MLTC at least 30 calendar days before the Nebraska Total Care contracting process is completed. Nebraska Total Care will submit all Subcontractor Evaluations 45 calendar days before the new MLTC Contract go-live according to Attachment 3 - Policies, Procedures, and Plans. **Figure 50.A** depicts the entire pre-

delegation timeline from initial submission through evaluation results to MLTC compliant with SOW Section V.C.14 and Attachment 3 - Policies, Procedures, and Plans.

Figure 50.A Milestones in Pre-Delegation Timeline



Subcontractor Oversight Program. Our comprehensive TPRM Program governs Subcontractor oversight activities. The TPRM Program ensures all Subcontractors comply with State and Federal laws, regulations, and pass-through Contract requirements and includes the following key elements:

- Clear accountability and transparency
- Execution of contract terms and agreements
- Delegation audits
- Performance monitoring
- Administration of Corrective Action Plans (CAPs)
- Enforcement of contractual penalties
- Quarterly Vendor Oversight Committee (VOC) Meetings
- Coordination of day-to-day business operations

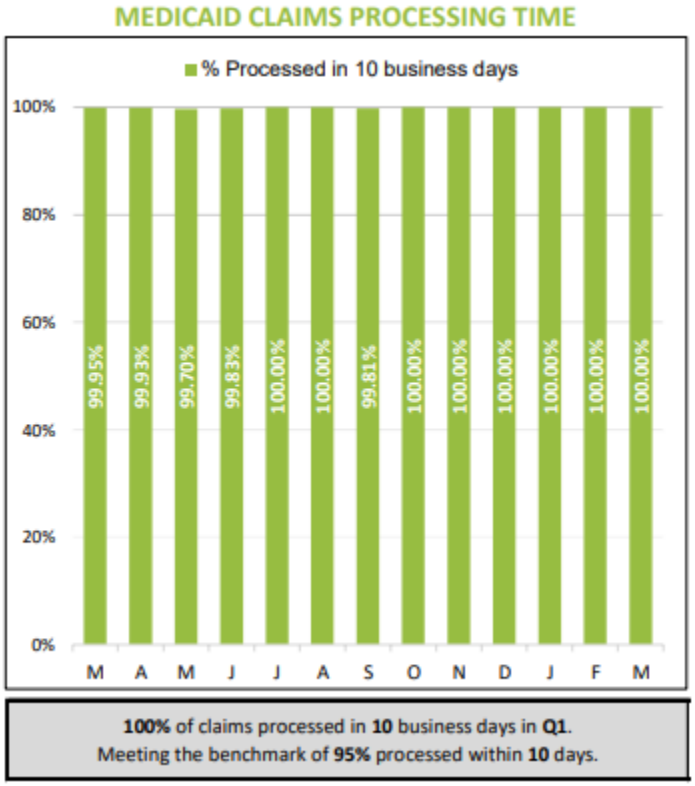
We use a team approach to Subcontractor oversight, starting with our Vendor Manager, who oversees day-to-day Subcontractor operations. The Vendor Manager reports to the Contract Compliance Officer (CCO) and is a member of our Compliance team. Our Compliance Team supports monitoring and auditing of Subcontractors, tracks key performance indicators (KPIs), and coordinates reporting and ad hoc requests from MLTC that require Subcontractor input. Each Subcontractor has a business owner who coordinates with our Compliance team to ensure the delegated tasks meet expectations and performance level standards. These business owners represent their areas of expertise. For example, our Pharmacy Director will have joint responsibility for the day-to-day oversight and monitoring of our Pharmacy Benefit Manager and the Compliance team, and the Vendor Manager. **Table 50.A** highlights examples of benefit management subcontractors, depicting their functional area oversight lead and critical metrics in monitoring, auditing, reporting, and compliance.

Table 50.A Oversight Lead and Key Metrics for Benefit Management Subcontractors

Subcontractor	Function	Nebraska Total Care Functional Area Lead*	Oversight Metric Examples
CaremarkPCS Health LLC (CVS)	Pharmacy Benefit Manager	Pharmacy Director	Prior authorization turnaround time (TAT), call center metrics, claim processing timeliness, network adequacy, and credentialing
Envolve Dental, Inc.	Dental Benefit Manager	Dental Director	Prior authorization TAT, call center metrics, claim processing timeliness, network adequacy, and credentialing
Envolve Vision, Inc.	Vision Benefit Manager	Medical Director	Call center metrics, claim processing timeliness, network adequacy, and credentialing
MTM	NEMT	NEMT Network Coordinator	Call center metrics, grievances, network adequacy, and credentialing

Vendor Oversight Committee. Our VOC, chaired by Nebraska Total Care's CCO, includes our Quality Management (QM) Coordinator, Compliance and Quality staff, functional area leads, and senior leadership such as our Chief Operating Officer, Medical Director, and Chief Executive Officer. The VOC monitors all functions delegated to Subcontractors, oversees interventions for any Subcontractor performance issues, and develops meaningful joint performance improvement plans to realize mutual operational efficiencies. Our quarterly VOC meetings include a review of Subcontractor performance dashboards and member/provider complaints. **Figure 50.B** depicts a sample Subcontractor dashboard used in performance tracking.

Figure 50.B Envolve Vision Medicaid Claims Processing Time March 2021 through March 2022



Subcontractor Scorecards

Nebraska Total Care requires Subcontractors to produce quarterly scorecard reports of KPIs on a tailored template based on NCQA, regulatory, and contractual requirements and delegated functions for additional oversight of trends, variances, and compliance.

Subcontractor Performance Monitoring. If a Nebraska Total Care Subcontractor deviates from our performance guidelines, Nebraska Total Care notifies the Subcontractor and takes appropriate action based on the severity and frequency of the deviation. We may use a formal Quality Improvement Plan (QIP) or CAP to address and promptly remediate performance or service deficiencies. We use the tools and resources described below in ongoing monitoring, reporting, and Subcontractor audits which occur on a risk-based schedule consistent with industry standards and State laws according to SOW Section V.K.v.

Compliance Management System. Our Compliance team loads our executed Subcontractor Agreements into our Compliance Management System for contractual oversight. Our Compliance Management System monitors contractual and regulatory reporting and certification requirements. Nebraska Total Care uses this tool for issue identification and remediation, Subcontractor Agreement assessments and audits, and TPRM policy maintenance. This system allows us to administer, monitor, assess, track, and audit Subcontractor Agreements. It provides a workflow-enabled policy and procedure formulation with a history of documentation and sign-offs. In addition, it includes the capability to distribute documents to the appropriate internal departments and Subcontractors, track specific Subcontractor compliance activities via auditable records, and store our ongoing assessments and audits of Subcontractor compliance risks.

TPRM Audits. Our TPRM audits prioritize contractual, MLTC, NCQA, and CMS requirements. We review policies and procedures specific to the delegated activities and the Subcontractor's overall performance. Consistent with CMS, ***we use a risk assessment methodology where the level of risk determines the format of the assessment***. For example, a high-risk level may warrant a comprehensive assessment of policies, in-depth file reviews of delegated services, and operations evaluation to ensure that the Subcontractor remains fully compliant in the provision of services on behalf of Nebraska Total Care. In comparison, a Subcontractor who demonstrates consistent performance may complete a questionnaire, a desktop policy review, or a focused file review to evaluate their performance in identified risk areas. Nebraska Total Care requires all Subcontractors to submit an annual attestation of their completion and understanding of key items such as staff background checks, training, and education; appropriate grievance and appeal procedures; Fraud, Waste, and Abuse (FWA) policies; and HIPAA compliance.

Centelligence KPI Dashboards. Our Centelligence reporting and analytics platform provides expansive Subcontractor desktop reporting and online KPI dashboards with drill-down capabilities. Nebraska Total Care monitors each Subcontractor's performance in categories that include provider calls, enrollment file processing, utilization management (UM) activity, network adequacy, credentialing, encounter data submissions, claims processing, and other delegated

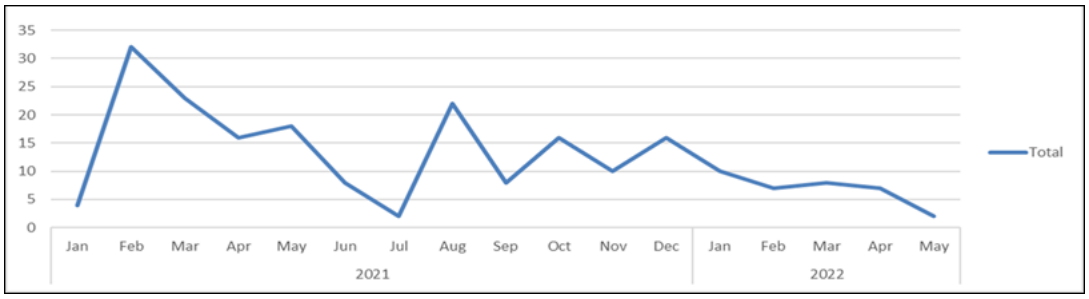
functions. Beyond daily monitoring, our VOC performs an in-depth review of these KPI Dashboards at least quarterly.

Centelligence Report Builder. Through Centelligence, we can report on Subcontractor datasets, including HEDIS, performance improvement plans, and other critical aspects of subcontracted operations. Our report builder enables our Subcontractor oversight team members to draw upon a library of reports covering administrative, operational, clinical quality, service delivery, compliance, and financial aspects of Subcontractor activities. Our Centelligence Report Builder also allows our oversight team to respond to ad hoc requests in the timeframe and manner specified by MLTC.

Subcontractor Corrective Action and Enforcement. If Nebraska Total Care identifies a variance or non-compliance using one of our TPRM oversight tools and resources, we validate the non-compliance and issue a formal remediation plan to address and correct the non-compliance. Noncompliant findings may result in a QIP or CAP. We employ a progressive approach to Subcontractor performance monitoring based on prevention, detection, and correction strategy. We prioritize ***early and frequent communication*** with our Subcontractors to ensure ***prompt identification and correction*** of deficiencies.

Communication with our NEMT Subcontractor, MTM, resulted in the creation of a Complicated Trips Committee in June 2021 to focus on members with frequent grievances and transportation challenges. This committee meets weekly and includes members of Nebraska Total Care's Compliance, Care Management, and Member Services Call Center staff. Regular collaboration with MTM in the Complicated Trips Committee has achieved reduced member abrasion and downward grievance trends.

Figure 50.C Complicated Trips Committee Grievance Reduction Impact



Quality Improvement Plans. Nebraska Total Care's QM Coordinator reviews any performance issue and in collaboration with our CCO requests a QIP, which includes:

- A summary of the performance issue or contract non-compliance that triggered the QIP
- The expected, measurable result indicating acceptable evidence for completion of the QIP
- A detailed action plan, including monitoring timeframes to complete required activities, the evidence required to demonstrate the correction, and the responsible party
- The due date for completion of the QIP

Upon acceptance of the Subcontractor's proposed QIP, we load the QIP into our Compliance Management System (discussed above) to monitor and document progress. Nebraska Total Care staff will generate status reports from our Compliance Management System for regular review by our CCO, the applicable functional area lead, our Board of Directors, and the Senior Leadership team as needed.

Corrective Action Plans. If the Subcontractor does not meet the QIP requirements by the timeframe required, our CCO will issue a formal notice of a CAP to the Subcontractor. The CAP issued will define the violated standards or service issue, the expected measurable result, a detailed action plan, and a due date for completion of the CAP. We capture the CAP details in our Compliance Management System to monitor and communicate progress.

Penalties/Termination of Contract. Nebraska Total Care strives to correct Subcontractor performance deficiencies through regular communications and detailed plans for performance improvement. We specify this approach in our Subcontractor Agreements for day one alignment. If a deficiency persists with a Subcontractor, our contracts include service level language that allows for the enforcement of penalties if the Subcontractor does not correct performance via a formal CAP. Nebraska Total Care Compliance documents a complete record of Subcontractor performance results against required standards. Our CCO discusses the nonperformance issue with the Subcontractor and notifies the delegate of any decision to invoke a sanction, including financial penalties, a reduction in the scope of work, or, ultimately, a termination of the agreement. We report all sanctions or penalties of Subcontractors promptly to MLTC.

Subcontractor Agreements and Training. Our Subcontractor Agreements include pass-through provisions of the SOW, policies, and procedures to support the delegated functions, cultural competency, compliance, FWA prevention and detection, privacy and security, and other standard Nebraska Total Care training focus areas. We require Subcontractors to

have a training program that adheres to their Agreements, MLTC, State, and Federal requirements. Subcontractor training by Nebraska Total Care is tailored by function and includes webinars and reference materials. We maintain training for new delegates, annual Subcontractor training, and training upon changes in processes and requirements of delegated functions. The applicable functional area at Nebraska Total Care may include relevant individuals from Subcontractors in their department-specific training efforts.

Ensuring Receipt of All Required Subcontractor Data. We contractually require Subcontractors to submit routine and ad hoc reporting to demonstrate performance and assist with State reporting deliverables. Throughout the life of their contract, we ensure Subcontractor reporting includes the necessary data elements and follows current frequency and submission standards. Nebraska Total Care Compliance in cooperation with the functional business owners use Subcontractor reports in daily operations and ongoing monitoring of delegated functions. Required reports depend on each Subcontractor's delegated functions and address areas such as:

- Network access
- Service utilization
- Prior authorization TAT, approvals, and denials
- Claims processing
- Call center volume and accessibility
- Complaints, grievances, and appeals

Figure 50.D captures specific data in Subcontractor reports used in Nebraska Total Care's oversight processes.

Figure 50.D Subcontractor Data and Reporting Elements

Metric Category	Description	Required Data	
Encounters	Timeliness	Initial Submission	Rejection submission
	Quality	Completeness	Accuracy
Network Adequacy	Urban	Primary Care Physician (PCP) Specialist	Hospital Behavioral Health
	Rural	PCP Specialist	Hospital Behavioral Health
	Member:Provider Ratios	Member:PCP	Member:Specialist
	Appointment Wait Times	Non-urgent Urgent	Emergent
Prior Authorization	Turn Around Time	Standard Expedited Notice to member Notice to Provider	Pharmacy Dental Concurrent Retrospective
Member Eligibilty	File Load Rate	% Load within Timeframe	
Claims	Processing and Accuracy	Clean Claim Non-clean claim	Claims processing accuracy
	Payment and Accuracy	Interest Payment Claims financial accuracy	Claims processing accuracy
Call Center	Time	Answer time	Hold time
	Quality	Abandon rate	Block rate
Grievances	Member	Acknowledgement Timeframe	Resolution Timeframe
Complaints	Provider	Acknowledgement Timeframe	Resolution Timeframe
Appeals	Member	Standard Urgent	Notice to member Notice to provider
Appeals	Provider Claims	Acknowledgement Timeframe	Resolution Timeframe

Encounter Data. Our Subcontractor oversight activities described above include ensuring our Subcontractors submit all encounter data in a timely and accurate manner, consistent with SOW Section V.S.10. As relevant, each Subcontractor's performance measures include encounter file delivery by specified dates each month. Each Subcontractor is required to submit a monthly report to us, which includes encounter-related analyses such as:

- Utilization of statistics and trends
- Medical claims processing statistics and trends
- Call center statistics and trends
- Provider network statistics
- Prior authorizations
- Encounter data acceptance rate

As part of our performance monitoring program, we evaluate Subcontractor compliance with encounter reporting requirements and take appropriate corrective action. To support timely and accurate encounter data submission, we meet with each Subcontractor regularly to review any encounter issues and results. MLTC is invited to participate in these sessions. Encounter submission technology supports error review and resolution services. ***Our encounter data excellence commitment is demonstrated in our pharmacy encounter rates, which consistently exceed 99% (above the 98% quality performance threshold) and average 99.47% since the start of 2022.***

Ensuring Appropriate Utilization of Health Care Services. Nebraska Total Care continuously monitors Subcontractors to ensure the appropriate utilization of health care services in compliance with SOW Section V.N. This includes authorization file reviews, weekly monitoring reports, and quarterly VOC meetings. In collaboration with Care Management and UM, Compliance monitors each Subcontractor's utilization reports and promptly identifies concerns or questions to initiate the appropriate follow-up activities necessary to address the issue. Compliance forwards identified issues that require additional insight from our QM and UM staff.

QM staff analyze utilization performance measures monthly, address any immediate issues, and forward recommendations to the Quality Assessment and Performance Improvement (QAPI) Committee if there are significant issues or additional support needs. The QAPI annually reviews and approves the Subcontractor's UM Program Description, work plan, audit findings, and evaluations. The UM Committee includes membership from each functional area, reviews utilization performance measures to identify trends of over/underutilization of services, and reports recommendations to the QAPI quarterly.

Depending on a Subcontractor's delegated functions, other staff may review utilization information and make recommendations. For example, Compliance oversees Subcontractor Program Integrity processes to prevent, detect, and correct utilization of FWA. Compliance uses methods such as electronic visit verification (EVV), explanation of benefits sampling, and monitoring to identify patterns of overutilization.

Ensuring High-Quality Delivery of Administrative and Health Care Services. Using the processes above, we ensure the delivery of subcontracted administrative and health care services meets Nebraska Total Care standards and SOW requirements. Our Compliance Management System allows us to systematically monitor Subcontractor compliance with initial contracts, any amendments, policies and procedures, and active State and Federal regulations. In addition, our pre-delegation and regular audits use standardized audit tools tailored by the Subcontractor function to meet SOW and NCQA guidelines. Our staff monitor Subcontractor performance on an ongoing basis through weekly, monthly, quarterly, and annual assessments and reporting.

Subcontractor performance must meet or exceed quality, operational, and administrative standards such as call center metrics, network management, claims processing, and appropriate utilization. Subcontractors must demonstrate quality maintenance, interventions, or improvements to comply with SOW Section V.M Quality Management, recommendations from our QAPI Program and Committee, all accreditation requirements such as NCQA, CAHPS, and HEDIS measures where relevant.

We solicit feedback and recommendations from Subcontractors to improve the quality of care, policies and procedures, and system performance and require them to participate in audits, any additional QAPI reviews, and interviews. Nebraska Total Care regularly monitors service performance measures, grievance and appeal trends, and member/provider satisfaction and disenrollment surveys in our oversight program. Examples of specific activities include:

- Compliance and Provider Services staff review monthly Subcontractor network listings to verify compliance with geographic access standards, such as for our delegated dental and vision networks.
- For Subcontractors with member and provider service functions, our Compliance staff reviews monthly call center metrics, including but not limited to the number of calls, abandonment rate, and speed to answer to verify compliance.
- Our Performance and QM Coordinator reviews our 24/7 Nurse Advice Line's daily reports of calls the previous business day to identify the need for follow-up care and track trends in after-hours calls.
- For claims processing Subcontractors, Compliance, and Finance staff review monthly reports that address the number and percentage of claims paid within the required timeframe, the amount of denied claims, and the reasons for denials.

To promote health equity and ensure access to services across Nebraska Total Care members, our QM staff and Health Equity and Diversity Committee further assess Subcontractor performance data related to specific enrolled populations. For instance, we analyze utilization or quality indicators by eligibility category, socioeconomic status, race, ethnicity, geography, language, or disease condition.

Ensuring Adherence to Grievance Policies and Procedures. We educate all Subcontractors regarding member grievances, our grievance system, and our grievance process according to the distinctions in

SOW Section V.H Grievances and Appeals. Nebraska Total Care contractually requires Subcontractors to comply with grievance policies and procedures, MLTC, State and Federal regulations, and NCQA standards. We review each Subcontractor's monthly performance metrics, which include but are not limited to:

- Total number of grievances
- Percentage of grievances resolved within the required timeframe (as expeditiously as a member's health condition requires, and always within 90 calendar days of receipt)
- Percentage of appeals resolved within the required timeframe (as expeditiously as a member's health condition requires, and always within 30 calendar days of receipt)
- Percentage of appeals overturned or denied and an explanation of each determination

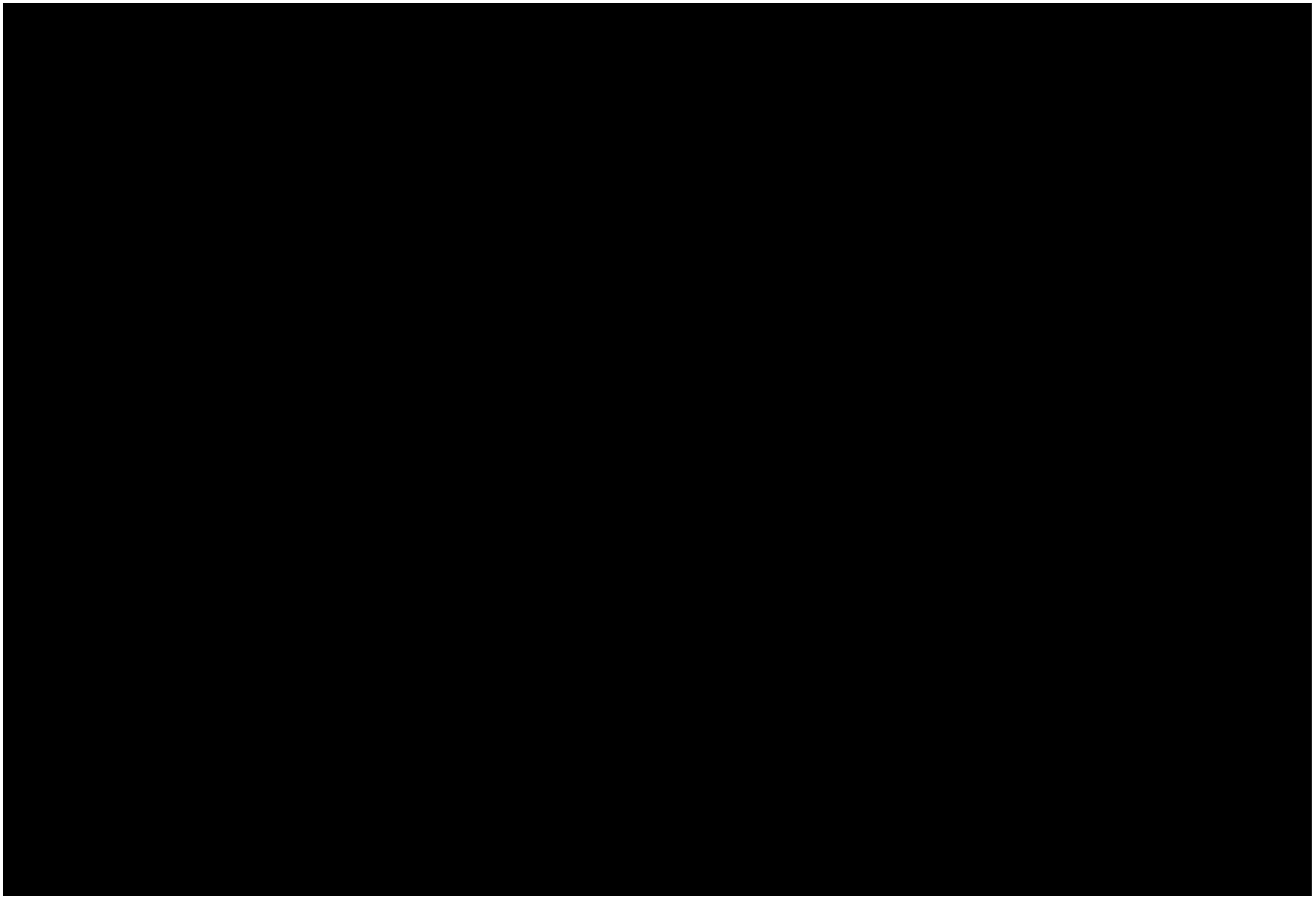
We review monthly performance metrics during VOC, Compliance, and QAPI meetings, and include oversight of grievances in the monitoring activities described above. Consistent with any grievance, we promptly act on grievances we receive from a member, provider, or MLTC regarding a Subcontractor's performance and provide written notice of grievance resolution. During audits and before implementation of any updates, Nebraska Total Care Compliance staff reviews the Subcontractor's grievance and appeal letter templates to ensure the inclusion of all required elements, such as a member's rights and responsibilities, a description of the grievance and appeal process, and access to the State's fair hearing system.

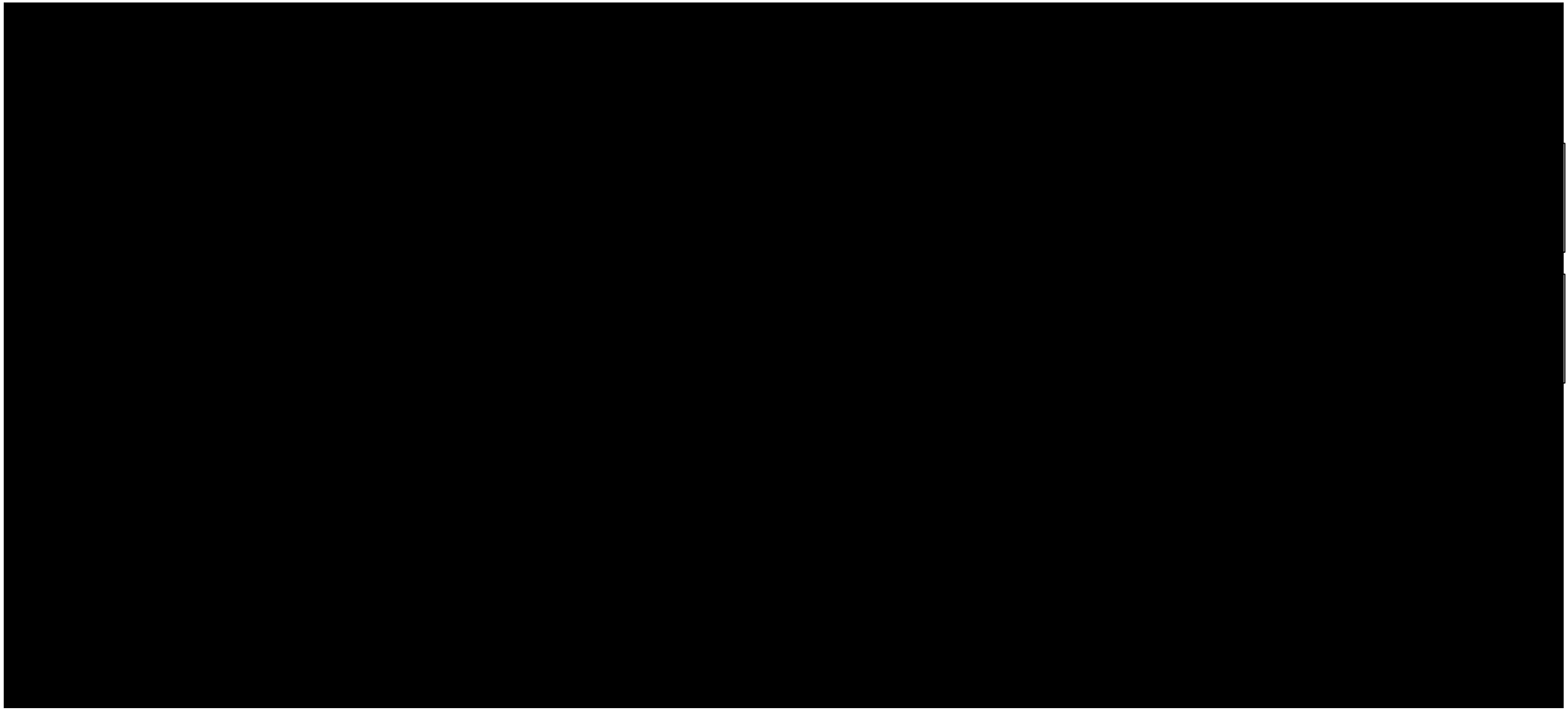
Ensuring Appropriate Reimbursement Rates. Nebraska Total Care Subcontractor Agreements include a provision for the payment of providers. Our provider reimbursement provision complies with SOW Section V.Q and ensures Subcontractors reimburse providers at rates no less than the published Medicaid FFS rate in effect on the date of service. We execute this by requiring Subcontractors to submit copies of their provider agreements for prior approval. Following implementation, Nebraska Total Care monitors adherence in post-delegation assessments and audits as discussed above, which include a review of downstream contracts. We also monitor provider appeals and complaints to ensure compliance with the reimbursement rate provision. Our Provider Claims Educator closely reviews testing data to assure claims payment accuracy before the Subcontractor implementation date and throughout their contract when changes are made to a Subcontractor's claims processing system.

RFP 112209 O3

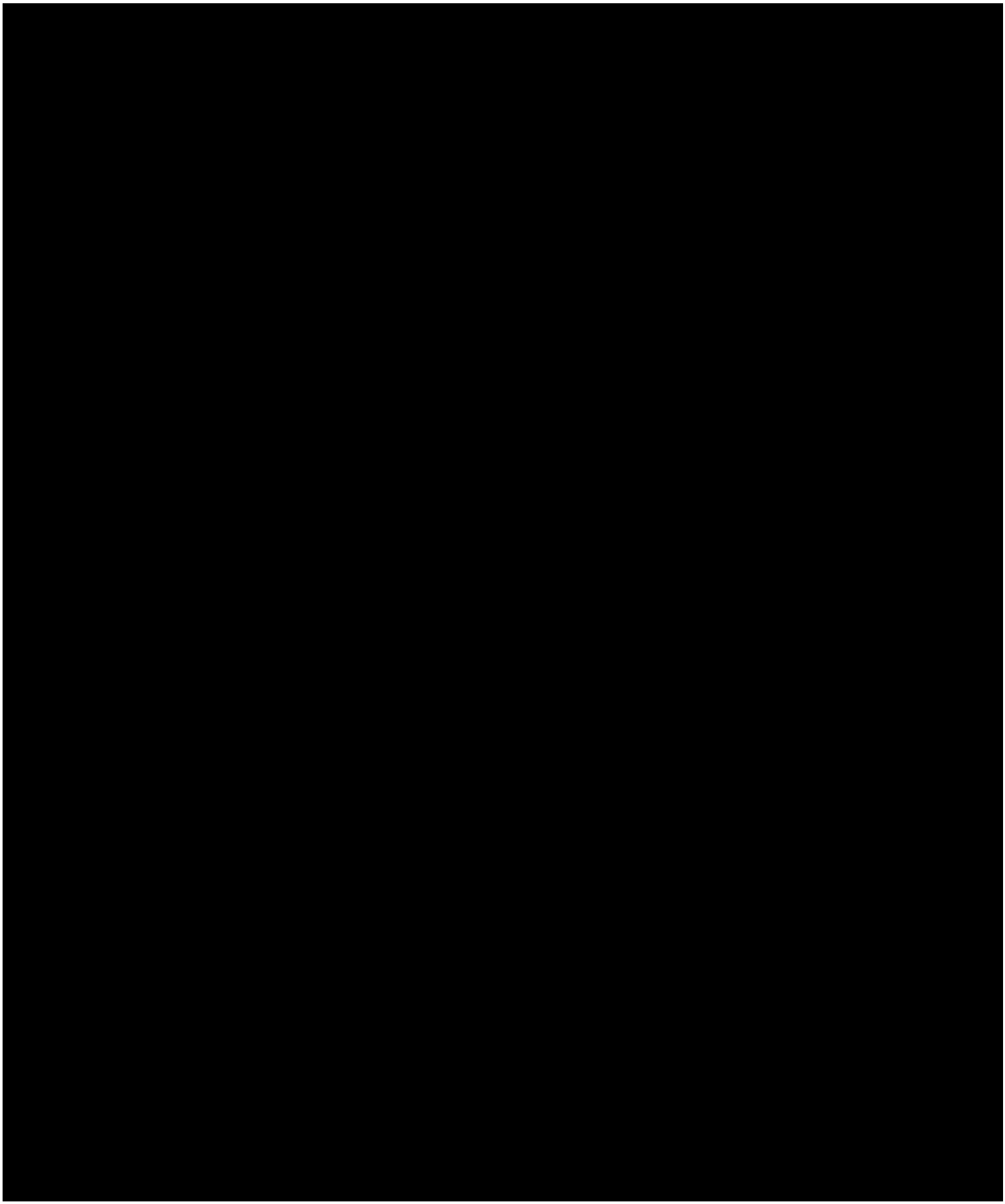
Attachment B.49

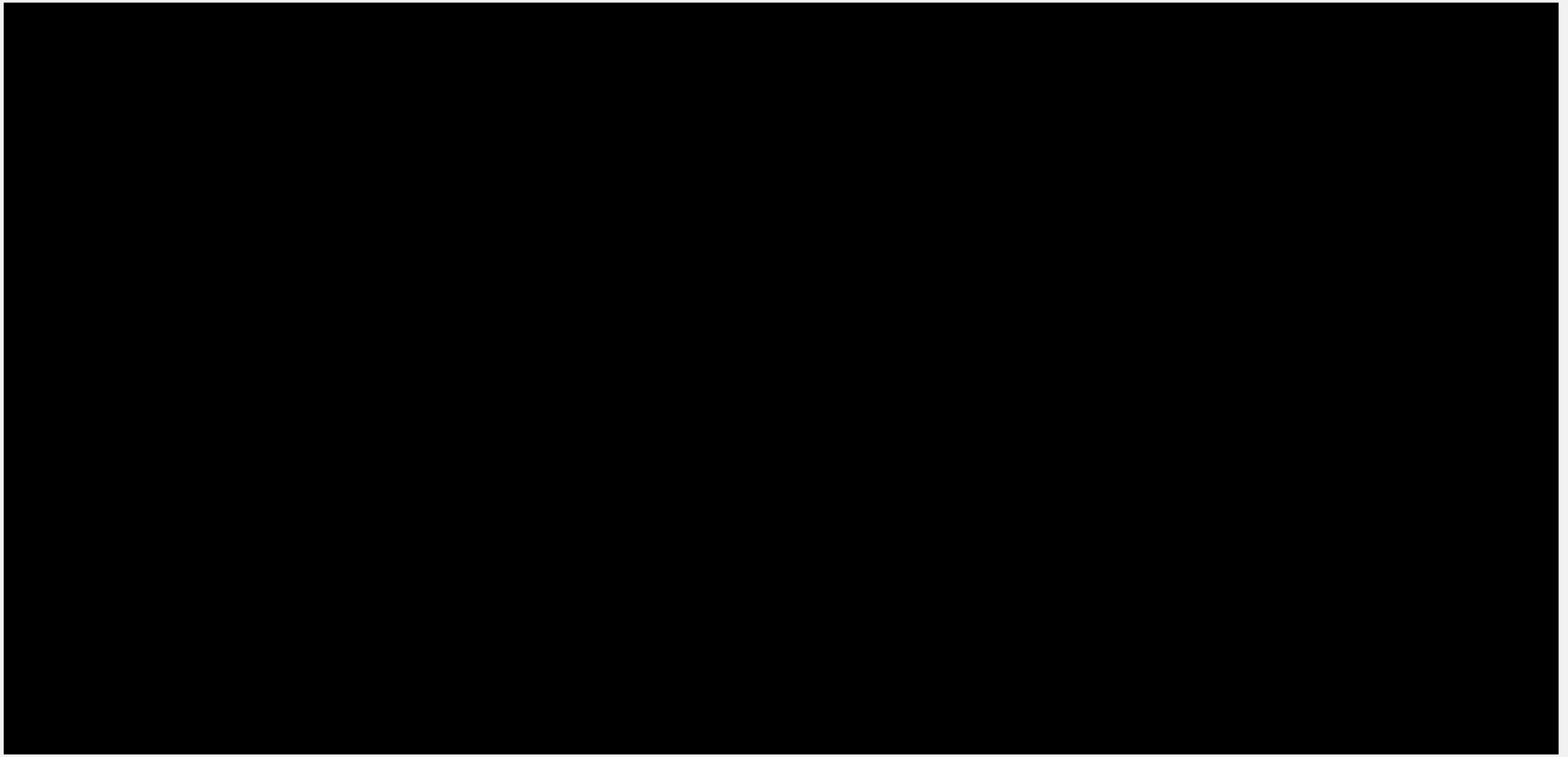
Subcontractor Organizational Charts



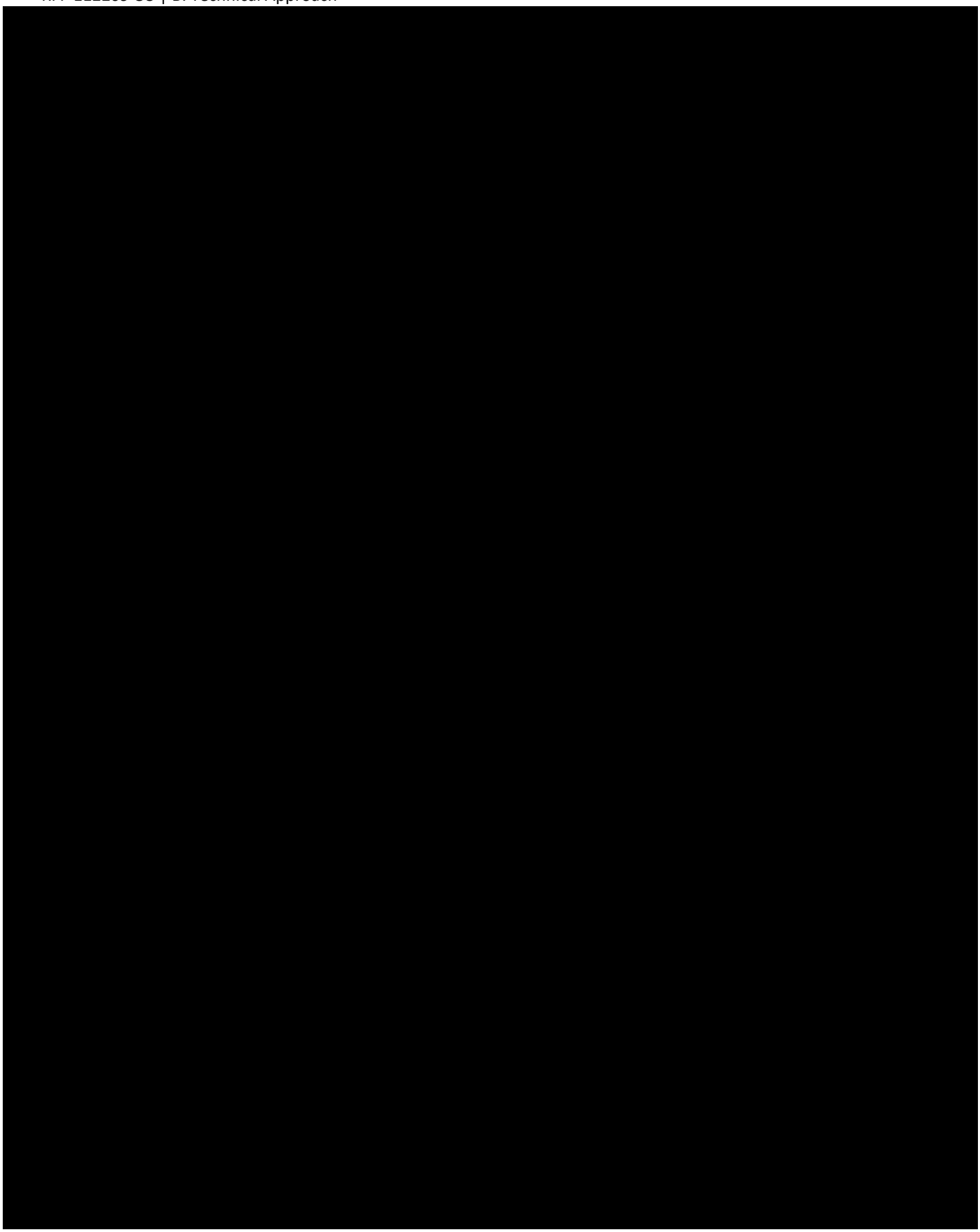


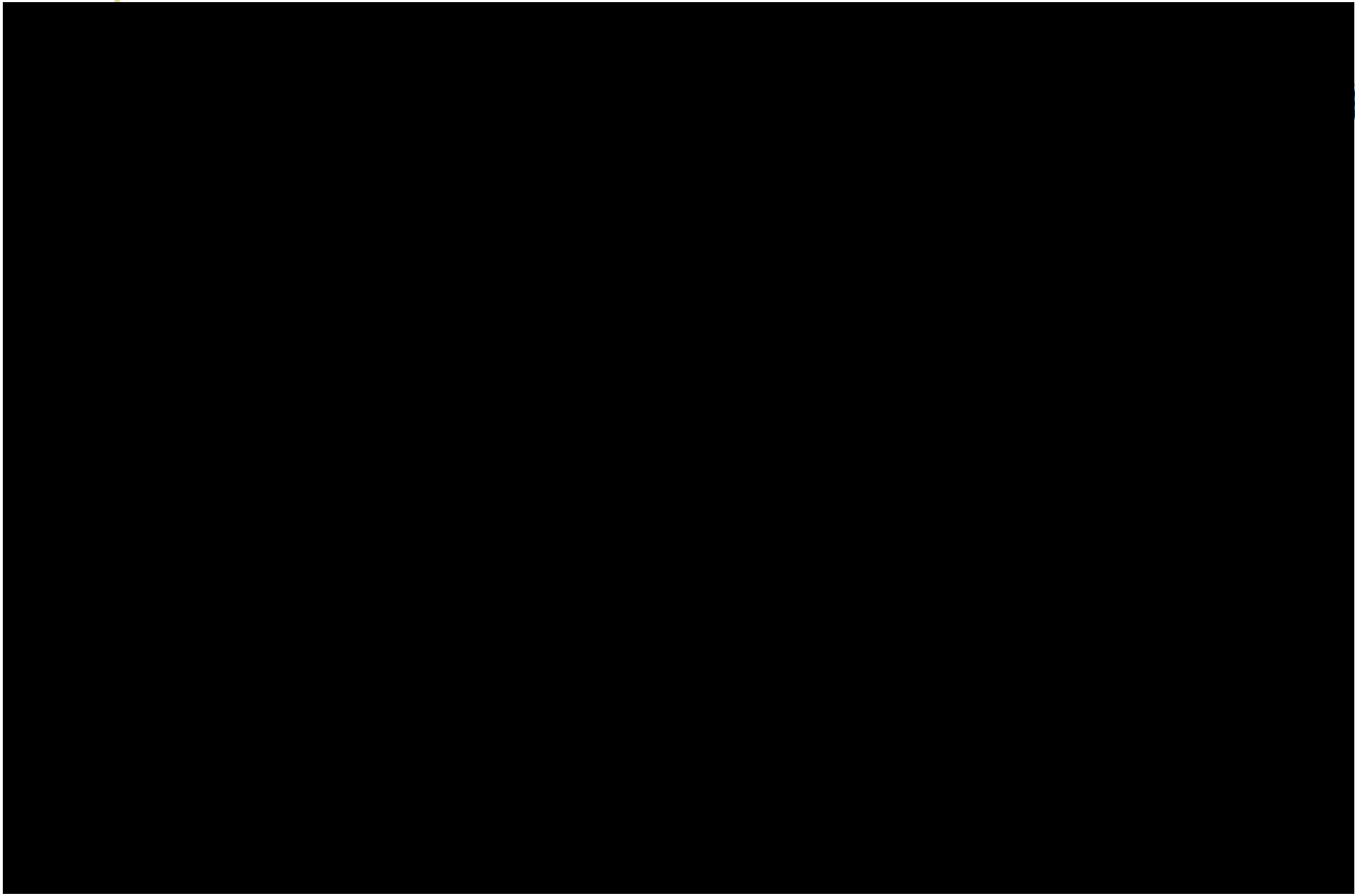
[redacted]

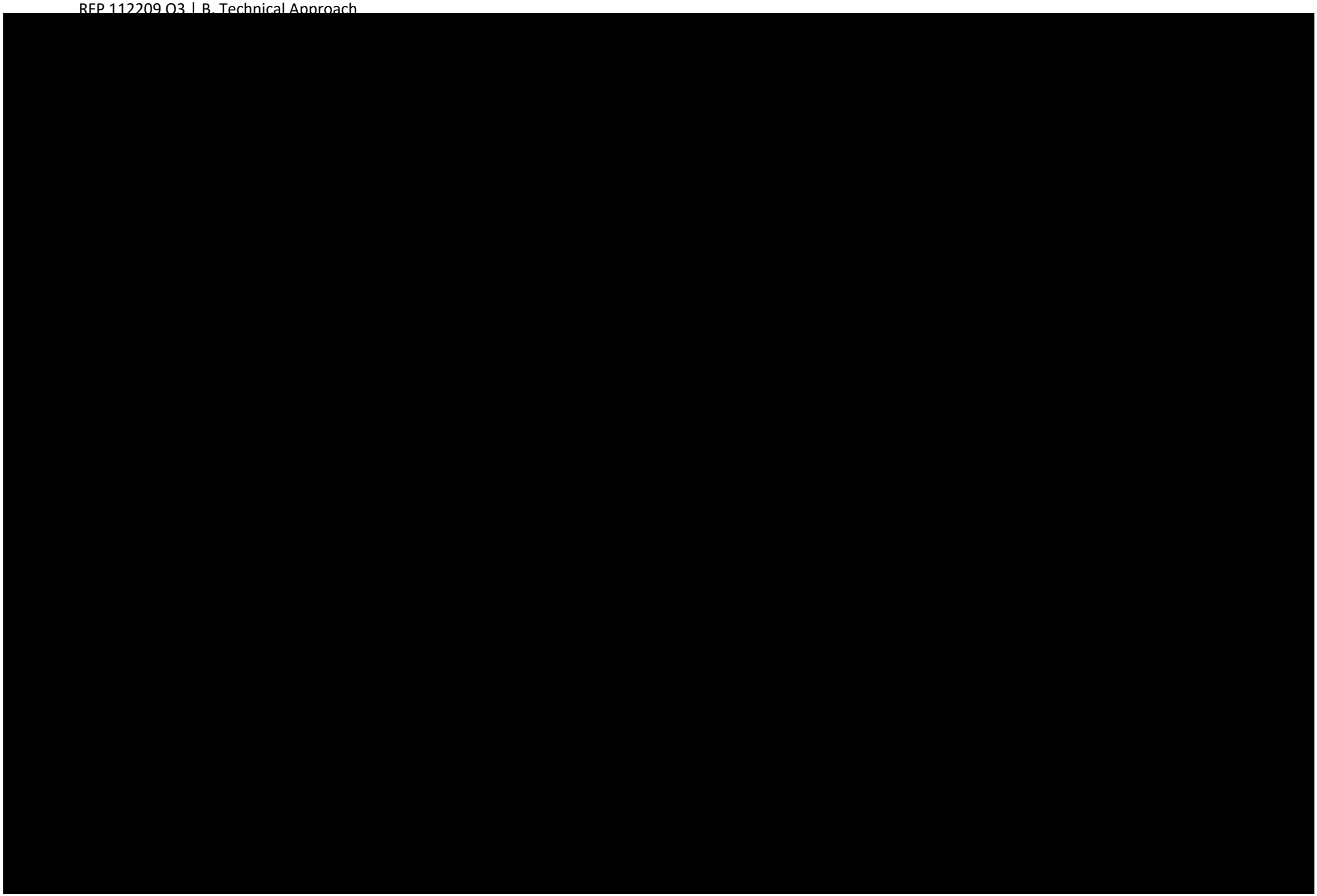


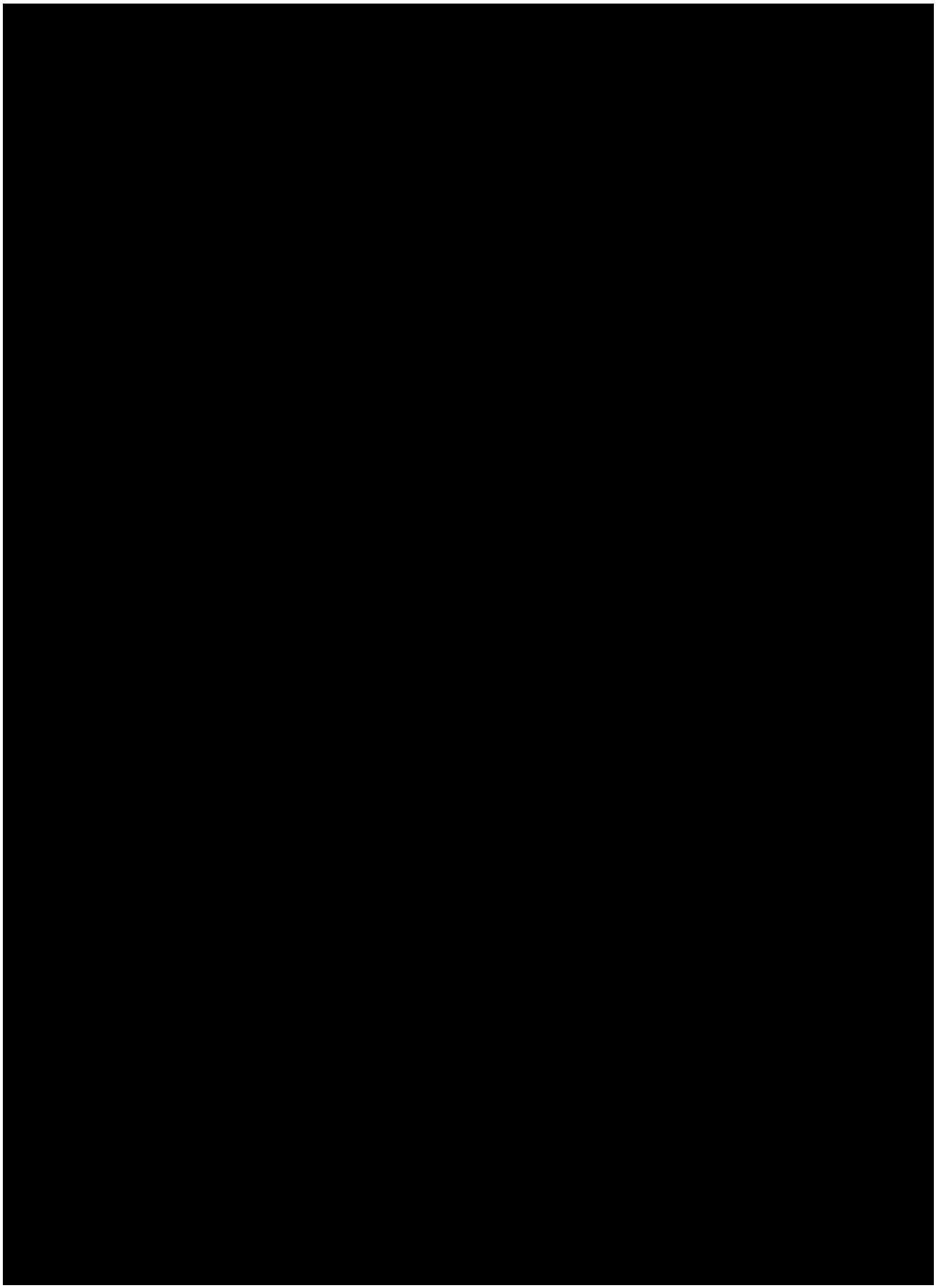


[redacted]









RFP 112209 O3

B. Technical Approach

V.L Care Management and Case Management

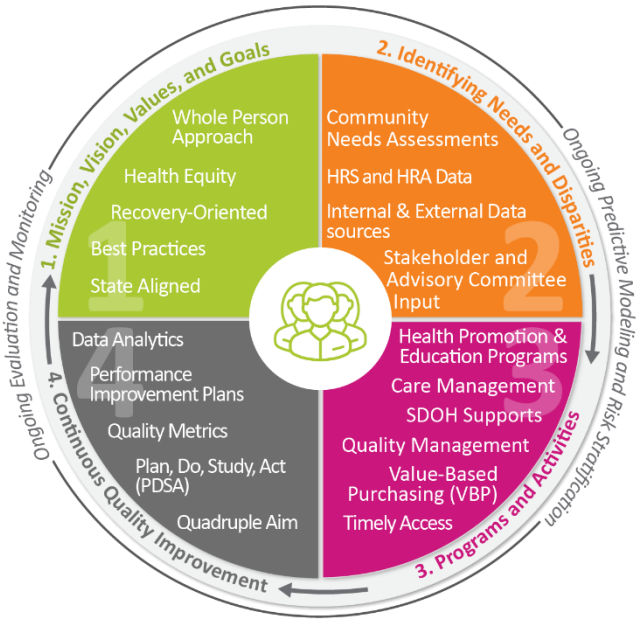
V.L Care Management and Case Management

51. Provide a comprehensive discussion of the Bidder's care management program, including:
• Coordination of services using person-centered strategies.
• Interventions focused on the whole person.
• Management of co-morbidities, including SUD.
• Incorporation of best practices for behavioral and mental health.
• Member engagement in self-management strategies.
• Social determinants of health, including risk and protective factors for behavioral health concerns.
• Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services.
Provide case studies and experience from other states illustrating the Bidder's ability to successfully address community differences in its care management approach.
Page Limit: Not applicable

Overview of Care Management Model and Approach

Nebraska Total Care has delivered comprehensive and person-centered Care Management services to Heritage Health members in Nebraska since 2017. Our integrated Care Management model, including Care Coordination, Disease Management, and Case Management is a key component of our NCQA-informed Population Health Management (PHM) framework. With the member at the center of everything we do, our PHM framework, illustrated in **Figure 51.A**, leverages population and individual member data and analytics to identify members who would benefit from additional support, including Care Management. Anchored by health equity, our approach is mission-driven, person-centric, and data-informed. A continuous process of identification, intervention, and evaluation, key elements of our PHM framework include:

Figure 51.A Population Health Management Framework



1 **Mission, Vision, Values, and Goals.** We derive our values and goals from our mission to transform the health of our community, one person at a time. Within each goal are programs and activities that directly align with MLTC's Quality Strategy and vision of a Healthy Nebraska. Using the Case Management Society of America's Integrated Care Management structure, we apply evidence-based and best practice approaches to align resources and stakeholders across complex health and social systems to promote health equity and whole-person care.

2 **Identifying Needs and Disparities.** We identify and address Physical Health (PH), Behavioral Health (BH), functional health, dental health, and Social Determinants of Health (SDOH) needs with input from multiple sources to inform our Care Management programs and activities. We synthesize information to get a complete picture of the individual and population-level needs of the membership, going beyond traditional means to capture member and community data, including 200+ external SDOH data elements.

3 **Programs and Activities.** Guided by the above inputs, we design, implement, and evaluate interventions to engage members and providers and improve outcomes. Interventions are driven at the population and individual member level. For individual members we deploy targeted health education and offer Care Management services and supports to members in need, as described throughout our responses to Questions V.L.51 to 63. Our PHM framework, supported by our risk stratification, predictive analytics, and Health Equity Improvement model, ensures our Care Management programs and interventions are relevant and customized. Our Care Management model operates under a local and integrated team-based structure, enhancing access to all covered and non-covered services, meeting holistic member needs, and improving population health through:

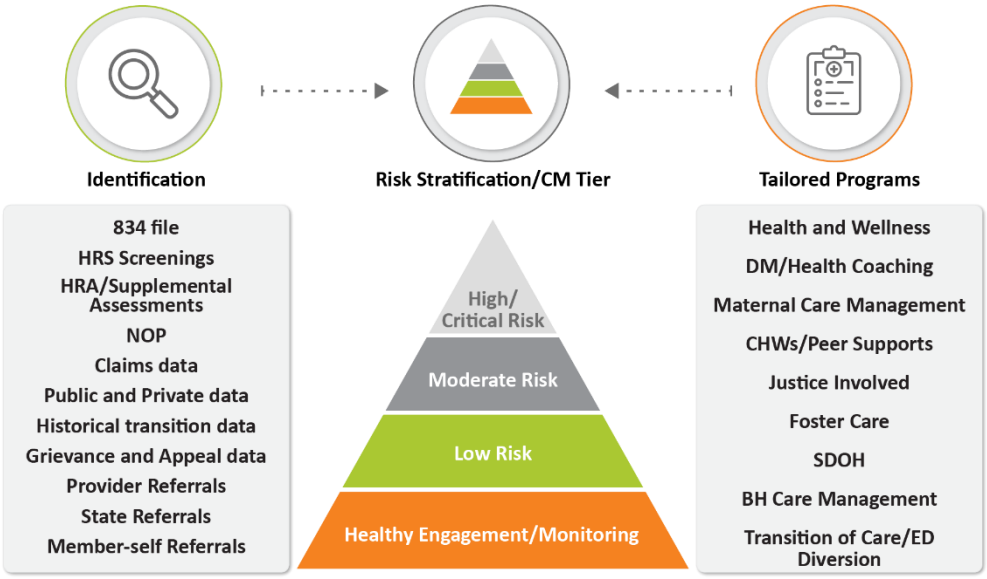
- A single point of contact: the member's Care Manager
- Member-centered, whole-person care that is recovery-oriented, culturally responsive, and encourages personal responsibility and member engagement
- Identification of each member's needs and strengths, using the Health Risk Screening (HRS) tool inclusive of the State's

components, our comprehensive Health Risk Assessment (HRA), and supplemental assessments, including our SDOH Mini-Screen
- Population-based predictive modeling and risk stratification that incorporates assessment, claims, authorization, SDOH, and demographic data, to stratify members into appropriate Care Management service levels and match with Care Management interventions and programs to achieve individual and population health
- Individualized plans of care that document member-determined strengths, goals, identified barriers, and interventions; plans of care outline how we will meet member-identified individual goals and address PH, BH, functional, dental, and SDOH needs
- Multi-disciplinary care teams consist of staff and external partners who work with members and families to support personal health and wellness goals and provide input to develop person-centered plans of care; the member determines care team participants, which at a minimum, include the member, their Care Manager, Primary Care Provider (PCP), and other treating providers
- Regular Care team meetings (in-person, virtual, or telephonic) are driven by member needs and preferences; the care team recommends interventions to help the member meet their identified health goals, address barriers, create innovative solutions, and communicate critical updates
- Technology solutions that support the sharing of health information with the member, the care team, providers, and others involved in the member's care, including our TruCare Cloud Care Management platform, secure Member Portal, Provider Portal, and Community Partner Portal

4 **Continuous Quality Improvement**. We apply rigorous scientific methods, such as Plan-Do-Study-Act, to evaluate impact, improve outcomes, and drive innovation at the individual and population levels. Powered by our Centelligene reporting and analytics platform, our predictive modeling tools leverage machine learning to identify and address ongoing and emerging needs before they reach a level of acuity which would cause a member to move into a high-risk status.

Care Management Model. Introduced above as a key intervention to promote population and individual health, our Care Management model matches members to the appropriate level and type of resources to meet their individual needs. Fully described in Questions V.L.52 and 53 below, we identify and stratify members into four levels of Care Management, as depicted in **Figure 51.B** below. Once stratified, assigned Care Managers, including Community Health Workers (CHWs) for healthy engagement, monitoring, and community outreach, engage members in Care Management services and support in accordance with their level of care and connect with tailored programs to meet their individual needs and personal goals.

Figure 51.B Care Management Levels and Programs

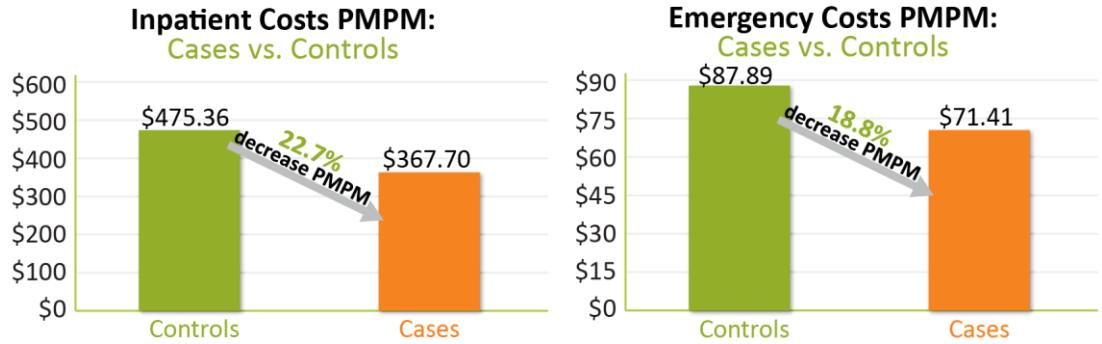


Care Management Outcomes. Based on our five years of experience and continuous improvement, we have seen positive outcomes for members engaged in Care Management in Nebraska. For example, members in Care Management with an intervention versus members eligible for Care Management who were unable to be contacted or opted out had ***33.9% fewer potentially preventable admissions and 8.8% fewer potentially preventable ED visits.*** In addition, members actively engaged in Care Management had ***121.8% more PCP visits*** (equaling over 5,866 more PCP visits per 100 member months per Year for members actively engaged in CM) ***and 30.6% shorter average length of stay for inpatient visits*** (approximately

24 days shorter).

National Outcomes. In addition to local success, an internal analysis of members in Care Management from 2017-2020 across all Centene Medicaid affiliate health plans (using the observational analysis method) found that, on average, our Care Management model resulted in significant savings in inpatient hospital and ED PMPM costs.

Figure 51.C Inpatient and Emergency Cost Decrease



Coordination of Services Using Person-Centered Strategies

Care planning is not something that is done "to" or "for" the Member. It is done *with* the member, and all decisions are predicated on the member's preferences, goals, and strengths. Plans of care are strengths-based and include cultural considerations; member-identified goals, preferences, and needs; steps for achieving goals; and family/caregiver and informal support participation.

Our Care Management model is centered around the member, who is supported by a skilled Care Manager who acts as the member's single point of contact. The role of the Care Manager and the member's care team is to work with and fully understand the member and their whole-person needs, strengths, goals, and lifestyle preferences. We achieve this through standardized assessments, motivational interviewing, person-centered thinking strategies, the principles of trauma-informed care, and active listening, with the member driving the process.

Nebraska Total Care deploys a range of tailored engagement activities to meet members where they are, creating a holistic, easy-to-navigate, and simplified experience. For instance, two members who appear clinically similar may present with very different levels of health literacy or readiness for change, requiring differing approaches for engagement. Using our person-centered, whole-person approach, we take the time to understand the member's needs, preferences, goals, and barriers and facilitate appropriate resources and follow-up as part of our Care Management programs. Supporting this work, our ***Community Health Workers (CHWs)*** function as an extension of our Care Management team to successfully engage members and meet them where they are in their community. Through our strategic partnership with ***Best Foot Forward***, we will provide outreach to members who are difficult to engage, including those we are unable to reach by telephone. This partnership includes location services, assistance with HRS and Notification of Pregnancy Form completion, and education on benefits and services available. Best Foot Forward has demonstrated a 58% success rate in reaching members who are otherwise difficult to reach in an affiliate market.

Recognizing Person-Centered Whole-Health Care Across the State

The Karma Boll Legacy Care Coordination Award was created in 2021 to honor the retirement of Karma Boll, Nebraska Total Care VP of Population Health. The award is presented annually to a Nebraska organization that demonstrates Karma's values of person-centered, whole-health, and cooperative member care. As the first recipient, the Great Plains Accountable Care Organization of North Platte brings together multi-dimensional professional teams and partners with community resource providers. The members they serve benefit from their creative care planning and progress toward long-term health and wellness as a result of their involvement.

Our Care Management program focuses on collaboration between us; the member; the family, guardian, or caregiver; providers; and others providing services to the member, including Home and Community Based Services Service Coordinators. We coordinate services furnished to the member with other services the member receives from the community and social support providers, per 42 CFR § 438.208(b)(2)(iv), ensuring that services are person-centered and tailored to the individual's unique needs.

Member Care Compass. Employing our ***Member Care Compass*** framework (described in detail below), engagement starts with our initial outreach and completion of the HRS where we first learn of and capture a member's preferences and care goals. Respecting the member's autonomy, we use this information to tailor outreach and engagement for content (such as

tobacco cessation materials) and engagement methods (such as texting for members with a cell phone). We invite members to enroll in appropriate Care Management programs and engage with us through the secure Member Portal and MyNTC Member Mobile App. We follow members through their journey using relevant touchpoints and data monitoring.

Person-Centered Center of Excellence. To ensure our staff always puts the person first, the Centene Person-Centered Center of Excellence (CPCCE) and Centene University developed an online blended learning experience to give Nebraska Total Care staff and providers access to the full person-centered program. Our Person-Centered Thinking training uses copyrighted training material developed by The Learning Community for Person-Centered Practices started in 1989 by Michael Smull and Susan Burke-Harrison at the University of Maryland. This training teaches our staff how to discover what is important **to** and **for** the member and how to help the member find balance. We use this training to identify the member's strengths, capacities, preferences, needs, and desired outcomes. It encourages member empowerment to make their own informed decisions, develop personally defined goals, and identify both community resources and paid supports to achieve the quality of life they choose.

Person-Centered Thinking

At Nebraska Total Care, Care Management staff are trained in Person-Centered Thinking and Motivational Interviewing.

Interventions Focused on the Whole Person

Nebraska Total Care incorporates Care Management interventions that focus on the whole person. Our programs improve the health of communities, one individual at a time. In treating the whole person, we don't see disease as a singular focus. For example, a member with diabetes has clinical needs often in concert with behavioral health and social support needs, such as poorly treated depression, and lack of transportation for medical appointments or inability to buy food or appropriately store medications. All of these needs must be addressed to improve clinical outcomes and promote quality of life.

Project Access

Nebraska Total Care is partnering with the Health Center Association of Nebraska (HCAN) to ***increase access to whole-person care*** for underserved populations. Together, we will:

- Support FQHCs to recruit and retain providers
- Streamline processes and upgrade technology
- Expand capacity through improved operational processes
- Develop workforce pipelines

Access to Whole-Person Care. In alignment with MLTC priorities, we have increased access to whole-person care, including primary care, BH care, and social support through strategic partnerships, technology solutions, and investments. We keep members healthy throughout the spectrum of primary and preventive care. A cornerstone of our approach is our integrated care model, which facilitates information sharing, cross-system coordination, integrated training, and seamless care delivery with one primary goal—meeting the whole-person needs of each member. We work with providers and community-based organizations to improve engagement; address SDOH, such as employment and homelessness; support members in BH crisis; and advance health literacy. Through strong and established community partnerships, such as OneWorld and HCAN, we are reducing health disparities and improving health outcomes and health equity, focusing on the whole person.

"Since the inception of Heritage Health, HCAN and Nebraska Total Care have maintained a collaborative partnership focused on enhancing and expanding access to care for Nebraska's underserved populations. Whether it is working together to address administrative questions to supporting outreach efforts in Nebraska's FQHCs, Nebraska Total Care has always maintained an open, cooperative relationship with us. Our current work on Project Access will profoundly change the ability of Nebraska's FQHCs to expand access to medical, dental, and behavioral health services; ensure the recruitment and retention of a mission-driven workforce and stabilize access to care in rural and underserved communities across the State. Nebraska Total Care understands the unique needs of Nebraska and works closely with community partners to address barriers to accessing health care. We are grateful for our long-standing partnership and look forward to expanding our mutual work in the future."

- Amy R. Behnke, J.D., CEO, HCAN

Integration to Support Whole-Person Care. Integration is a key strategy in the delivery of whole-person care. With the integration of dental services, our approach to integration will expand to include PH, BH, social services, and dental health. We currently dispel stigmas associated with BH and increase access and availability of BH services through education and training; early identification using screening tools; a full continuum of BH providers; and integrated, whole-person care and

support. We promote clinically integrated training such as BH Screening Tools, BH 101s (Anxiety, Depression, PTSD), Cultural Competence to Cultural Humility, Conscious and Unconscious Bias, Integrated Care, Mental Health First Aid, Suicide Risk, Substance Use, Working with Tribal Communities, and Social Isolation. We will engage dental providers in screening members for SDOH and educate PCPs on the importance of and how to refer to dental services.

A Whole Person Focus on Health Equity. Our award-winning ***Health Equity Improvement Model*** supports whole-person care by identifying disparities through integrated quantitative and qualitative data and distilling them down to identify root causes and help activate change. We identify SDOH barriers impacting our members through our SDOH Dashboard, that uses geomaps to overlay SDOH data from our ***Neighborhood, Economic, and Social Traits (NEST) tool,*** which analyzes over 200 data points to predict the risk of adverse member health outcomes based on social drivers. Nebraska Total Care's Health Equity and Diversity Committee include representatives from our organization, including BH, quality, population health, network, pharmacy, and community outreach, and staff with public health, epidemiology, and statistical expertise. The Committee will expand to include our Dental Director and external representatives (members, providers, CBOs) from across the State and across disciplines.

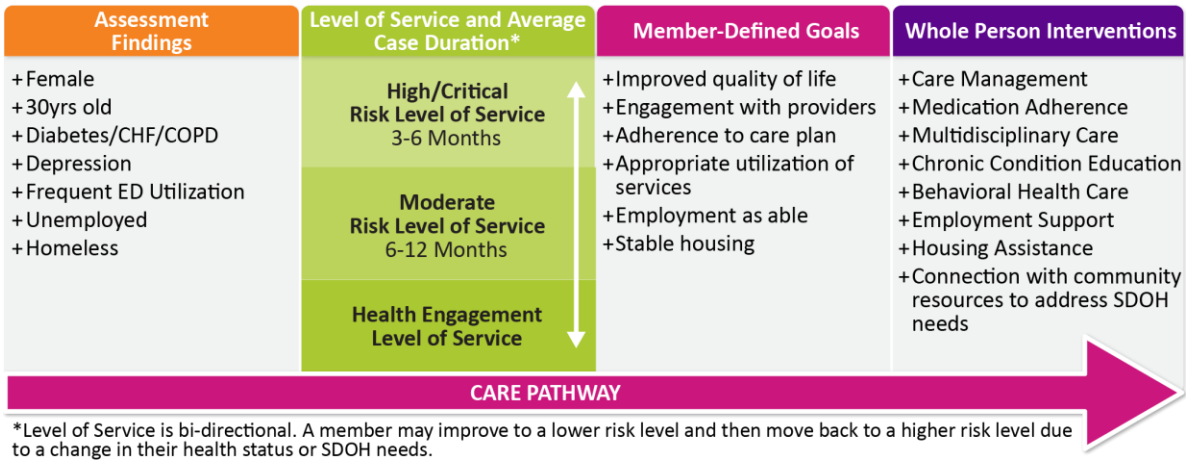
Specialized Teams Supporting Whole-Person Care. We embrace Maslow's hierarchy of needs, knowing that social needs must be addressed before individuals can fully engage in their health care. As part of our team-based approach, we have specialized teams to support members and their Care Managers in addressing a member's social needs and locating and connecting members to needed services. For example, our ***Housing Team*** consists of staff with technical knowledge and relationships with the State's Housing Continuum of Care. Our team consists of a Program Specialist, a CHW, a Community and Disability Liaison, and our Systems of Care Liaison who work to help place members in safe, quality, and affordable housing.

Addressing 'Kadisha's' SDOH Needs. Kadisha is a four-year-old with dysphagia, encephalopathy, and spastic quadriplegic cerebral palsy. Her dad is the primary caregiver to her and her two siblings. Upon engagement in Care Management, Nebraska Total Care discovered the family was unhoused and living in a Motel 6. Kadisha's Care Manager contacted Least of My Brethren and St. Vincent De Paul. These organizations provided funding to cover utility deposits as well as furniture and appliances so that the family could move into a home and out of the motel. The Care Manager offered to represent the father at a meeting with St. Vincent De Paul so he would not have to take off work and lose income. Using our 'social needs first' approach, the Care Manager was able to help the family obtain safe and secure housing and now the father will be able to focus more on Kadisha's health care needs. The Care Manager maintains regular contact with Kadisha and is actively pursuing respite care, waiver benefits, and other supports to ensure Kadisha can stay healthy at home.

Another example is our ***Foster Care Team,*** which includes licensed clinical staff, a Program Specialist, and a Foster Care Liaison to directly support the member, adoptive or foster parent(s), and the child/youth's Division of Child and Family Services Caseworker. Our team has a combined 55 years of experience in the Foster Care System, providing a wealth of resources, connections, and community networking. We work to identify and close care gaps, remove barriers, share information with applicable partners, advocate for needed services, and facilitate linkages between health care and community-based service systems. ***Our efforts to coordinate care with foster youth and DCFS have proven effective: members in foster care have the highest CM intervention rate among our membership; from 2020 to 2021, foster youth PCP visits increased by 13%, and ED utilization decreased by 50% for members in foster care enrolled in Care Management services.***

Care Pathways. Our Care Management team uses evidence-based guidelines and our proprietary care pathways for complex populations to guide the plan of care development. This is significant for individuals with multiple chronic conditions, co-morbidities, and complex health conditions complicated by SDOH that can impede access to care and adherence to the plan of care. For example, when we identify a member with complex and co-morbid conditions, such as depression and diabetes or congestive heart failure with unstable housing, our Care Managers have access to proven care pathways that can be tailored to address the member's whole person needs. Care pathways include clinical treatment protocols and Care Management interventions to guide the development of a whole-person plan of care, as illustrated in the example Care Pathway in **Figure 51.D**.

Figure 51.D SAMPLE Care Pathway to Support a Member with Complex Needs



*Level of Service is bi-directional. A member may improve to a lower risk level and then move back to a higher risk level due to a change in their health status or SDOH needs.

Management of Co-morbidities, Including Substance Use Disorder (SUD)

With 36.5% of Nebraska Total Care members having two or more chronic conditions and five of the top ten chronic conditions for all members being BH/SUD-related, Care Management staff are well trained and well equipped to support members with co-morbidities. We offer a suite of chronic condition programs that recognize the interplay of co-morbid conditions and focus on helping members understand and manage their conditions. Common program elements include:

- Motivational interviewing and member-centric assessment and planning
- Condition-specific and co-morbidity assessments and targeted interventions
- Clinical practice guidelines and evidence-based practices
- Condition-specific educational materials geared to specific populations, such as children, non-English speakers, and members with low literacy levels
- Technology solutions such as remote patient monitoring and the use of email, text messaging, and mobile applications for health information, reminders, and support
- Care gap closure programs and health alerts aligned with HEDIS metrics
- Medication support, including outreach by pharmacy staff
- Access to our Member Call Center, Nurse Advice Line, and Care Management staff
- Access to our Findhelp Community Resource Platform to link members to community resources and ensure appropriate follow-up through a closed-loop referral system

Health Coaching and Self-Management Skills. Our integrated Disease Management programs use health coaching to help members manage chronic conditions and prevent avoidable ED visits. We provide tools and interventions to help individuals diagnosed with chronic or co-morbid conditions adopt healthy behaviors and decrease risk factors. We educate members about their condition(s) and the options available and empower them to take charge of their health. For example, CHWs educate members about appropriate screenings (annual HbA1c testing and retinal exams for diabetes); appropriate self-monitoring for specific conditions (such as daily weights for congestive heart failure, blood glucose monitoring for diabetes); and how to avoid environmental triggers (allergens in the home that exacerbate asthma). To further educate members, our written materials and verbal communications encourage adherence to care guidelines, to improve health outcomes for the members.

Supporting Members with Co-morbid BH Conditions. 22% of our members have co-morbid PH and BH conditions, accounting for 46% of ED and 38% of inpatient claims. Integrating services is a large focus of our Care Management approach to best serve these members and avoid unnecessary utilization. Care Managers with expertise in chronic conditions are part of our Care Management team. They work directly with the member and the care team to ensure everyone involved in the member's care understands the impact each BH or PH condition has on the other. For example, a new chronic condition diagnosis may lead to depression, or a member with serious mental illness may ignore symptoms of a PH condition. We know that members with schizophrenia have a higher risk of diabetes, and members with hypertension are at higher risk for anxiety and depression. Their Care Manager may solicit input, referrals, and assistance from an RN, a Care Manager with expertise in metabolic management, and a CHW whose local resource knowledge can facilitate connections to community-based recovery groups and virtual supports. For example, we offer ***myStrength***, our online BH resource tool, with customizable self-care resources that provide educational support to improve mental health and overall wellbeing for members experiencing BH conditions.

Nebraska Total Care is implementing a ***Schizophrenia Spectrum Disorder program*** to provide increased support for members with a mental health diagnosis who are also diagnosed with co-morbid medical conditions. Given the correlation between schizophrenia and coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and asthma, it is vital to understand the members' entire wellbeing. This program aims to enhance the scope of treatment for members with a schizophrenia spectrum disorder or other psychotic disorders. We do this by providing a comprehensive assessment, service planning, and Care Management to acquire needed resources and address multiple aspects of a member's life in partnership with members, caregivers, specialized providers, and community social service agencies. Desired results include reducing barriers to care and motivating members to continue in treatment and improve outcomes. For each member interaction, we create and prioritize short-term and/or long-term goals in collaboration with the member, provider, and caregiver.

Supporting Members with Co-morbid SUD. Our specialized team of SUD Care Management staff, including Licensed Alcohol and Drug Counselors, offers holistic support for members with comorbid SUD. Our BH Medical Director, Dr. Wendy Welch, ensures we fully integrate our condition management programs into our Care Management program. As an advisor to the American Society of Addiction Medicine and an addiction specialist, Dr. Welch ensures our Care Management program aligns with evidence-based practices to serve members with co-morbid conditions, including co-morbid SUD. We offer targeted interventions through our SUD framework of prevention, treatment, and recovery support, as shown in **Figure 51.E**. Specific interventions include:

- ***Health Assistance, Linkage, and Outreach (HALO)*** is our national, award-winning SUD program, which has demonstrated success. A nationwide analysis projects average cost savings of $204 PMPM for members actively engaged in the HALO program. This quality-based integrated care model incorporates provider and community support and partnerships to promote best practices. This program includes our ***Narcan Education Program,*** which will prevent opioid-related overdoses. We will identify members who have presented at EDs with an opioid overdose and engage their providers to prescribe Narcan through retrospective drug utilization review (DUR) reports. As needed, we will follow up with members to encourage Narcan utilization.
- Linkages to ***Peer Support*** through organizations such as Safe Harbor and Peer-Run Family Organizations.
- Our ***Start Smart for Your Baby® Strong Beginnings program*** is an integrated BH and Care Management program that assists members who have or are at risk of having SUD during pregnancy. Our Strong Beginnings team uses multiple data points (SUD claims, opioid prescription, HALO predictive analytics) to identify and outreach to members to complete a Screening, Brief Intervention, and Referral to Treatment (SBIRT). Supporting early intervention and prevention, this program identifies members early in their pregnancy to engage them in our Start Smart for Your Baby® program, treatment, and behavioral change.
- Using the ***principles of Trauma-Informed Care***, our staff approach interactions with each member with compassion and a goal of addressing the person's whole health.

To further support members with co-morbid SUD, Nebraska Total Care developed an innovative pilot with the ***University of Nebraska Medical Center*** to offer opportunities for outreach and engagement to members presenting to an ED for alcohol use disorder. We engage these members after they have presented to the ED and connect them to BH and/or PH services, knowing most of these members have co-morbid conditions. Our BH Medical Director may consult with the member's BH or PH provider to provide peer-to-peer consultation, including discussing medications for alcohol use disorder. ***Initial outcomes show we have proactively identified 35 members and have begun to actively engage these members in Care Management services.***

Incorporation of Best Practices for BH

At Nebraska Total Care, BH is integral to our care and fundamental to members' wellbeing. We have built our reputation on person-centered care that integrates PH, BH (including mental health and SUD), dental health, functional needs, and SDOH. We leverage a combination of high-touch Care Management, multi-disciplinary relationships, and analytics to ensure that we identify BH needs early, connect to treatment, and help members maintain through recovery. Our person-centered approach is grounded in principles of recovery and the State's Principles of Care. We approach each member with hope for their recovery as they define it, meeting them where they are, and actively engaging them in treatment planning and self-

identifying goals. We stratify members with significant BH needs into the Moderate or High/Critical Risk level of service and assign a Care Management BH Clinician who functions as the member's single point of contact.

The following best practices are foundational to our BH program:

- **Person-Centered, Family Driven, and Age Appropriate:** Our multi-disciplinary Care Management model ensures that each person has a specialized circle of support and the right services, in the right setting, at the right time to promote their recovery and sustain their wellness. For example, members can choose their provider to the fullest extent possible at all levels of treatment. We ensure all members and providers have the tools and resources they need to address BH needs. For example, to bring awareness to the availability of the 988 Suicide & Crisis Lifeline, we have curated a toolkit to communicate with members, providers, and community partners. Based on SAMHSA recommendations, the toolkit includes member educational materials, social media posts, Provider Newsletters, and resources for community-based organizations to raise awareness of this critical resource.
- **Coordinated:** Services for members are part of an overall coordinated system of care that ensures access to BH treatment services to improve the overall health of each member. To the fullest extent possible, we provide services in the community where the member lives. Whether the member is in foster care, experiencing a crisis, in the hospital, or facing homelessness, they have a Care Manager assigned based on their primary needs, a customized care team to support their recovery, and a comprehensive plan of care that reflects their whole-person needs.
- **Trauma-Informed:** 100% of our staff have completed training in adverse childhood events and trauma-informed care. This helps us provide effective health care services with a healing orientation.
- **Timely:** Our approach to BH screening, assessment, referral, and treatment has ***many access points and no wrong door***. We utilize an array of predictive analytics, technology supports, provider trainings, and tools to ensure that we identify members with BH needs early for proactive outreach and customized engagement in care.
- **Recovery-Oriented and Resiliency-Based:** At Nebraska Total Care, every staff person uses each touchpoint as an opportunity to connect with members in meaningful ways, build relationships, and link them to local treatment services and support.
- **Integrated:** Our care teams, Provider Portal, provider training and support, and numerous telehealth and technology solutions all come together to help members address functional needs and resolve barriers to health. We facilitate seamless planning and coordinated linkages between BH, PH, and community-based services for every person, ensuring active treatment is provided to each member when needed.
- **Collaborative:** We have built strong relationships with our community mental health centers, PCP partners, hospital providers, and community-based social service partners. They value our clinical training, case conferences, and extensive telehealth and technology support to ensure BH care access and quality. We partner with organizations like Bryan Health and Community Alliance to work with us through a seamless team-based approach for the member. As the provider of BH services, they offer a level of expertise and member relationship that fosters greater engagement and insight into the individual's needs, preferences, triggers, and readiness for change.

Supporting BH Service Connection Through Domestic Violence Training

We partner with the National Domestic Violence Hotline to produce ***trauma-informed training*** for both employees and providers to improve confidence in identifying and addressing domestic violence.

Initial outcomes suggest strong improvement in providers' confidence and ability to identify, respond to, and provide appropriate resources related to members experiencing intimate partner violence.

"Community Alliance has a very collaborative relationship with Nebraska Total Care. This ranges from formal to informal conversations, training, and problem-solving discussions to working on a pilot for value-based contracting. Nebraska Total Care staff have taken the time to better understand our programs and the individual needs of those we serve. If and as concerns arise, they are quick to respond, problem-solve, and work with us to find solutions. They have been responsive to questions and feedback and adjusted when some collaboration efforts became too overwhelming for us. The approach that Nebraska Total Care takes is focused on helping to improve a member's engagement in treatment and ultimately to help them in their recovery.

- Aileen Tedy, CEO, Community Alliance

To ensure these best practices are operationalized in every member interaction, we train staff to engage members using evidence-based methods, as shown in **Figure 51.F.**

Figure 51.F Nebraska Total Care Offers Training on Evidence-Based Practices, Supporting BH Care

Engagement Skills Training. Skills to establish trust, credibility, and rapport with each member.

Cultural Competency/CLAS. Train staff on unconscious bias, cultural sensitivity, and crucial conversations, in addition to specific cultural traditions and beliefs surrounding care and training on the Culturally and Linguistically Appropriate Services (CLAS) standards.

Mental Health First Aid. A skills-based training course that teaches participants about mental health and substance-use issues to help identify, understand, and respond.

Person-Centered Thinking. Built on the core concept of person-centered practices, providing instruction on how to discover what is important to and important for the member, and how to support the member to find balance.

Motivational Interviewing. Trains staff to take a partnership approach with members, using open-ended questions, affirmations, reflections, and summarizing to assess attitudes on change and appropriate next steps.

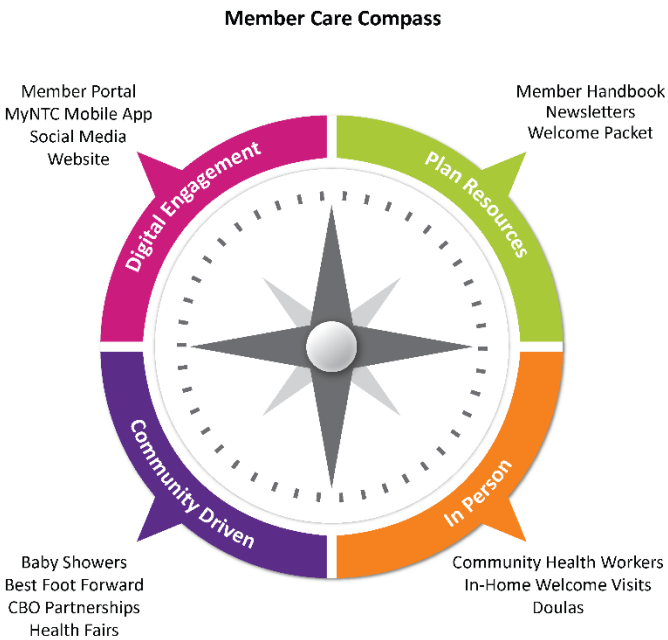
Trauma-informed Care. Identifying and understanding the effects of trauma, including Adverse Childhood Experiences (ACEs), on development and behavior in children and adults are crucial in assessing each member's needs and in understanding the context of behavior.

Gender & Sexuality Diversity. Competency training to improve knowledge, skills and strategies regarding LGBTQIA+ healthcare service needs and delivery.

Member Engagement in Self-Management Strategies

Nebraska Total Care takes a no wrong door approach to member engagement. Our ***Member Care Compass engagement model*** outlined in **Figure 51.G** below, fosters personal responsibility and healthy lifestyles and engages members in preventive care, wellness services, and self-management strategies. Our assertive approach includes home visits, Member Connect Stations, and multimodal outreach, including social media, email, text, written materials, telephonic outreach, Member Portal, and our MyNTC Member Mobile App. We offer appointment-scheduling assistance to ensure members have access to ambulatory care, including three-way calls with the member and provider, and assist with arranging transportation, ensuring members can get to their appointments.

Figure 51.G Nebraska Total Care's Member Care Compass Offers A No Wrong Door Approach to Engagement



We provide tools and interventions to help individuals adopt healthy behaviors, decrease risk factors, manage chronic conditions, and prevent ED and inpatient visits. For example, we offer continuous glucose monitoring for members with diabetes, enabling them to actively participate in managing their condition. We connect members to group visits to encourage self-management of various PH and BH conditions, such as pregnancy, diabetes, or tobacco use. For example, we provide transportation to group prenatal classes and connect members to the State's virtual and in-person tobacco cessation programs.

Self-Management Resources. We promote member self-management and empowerment through education, communication, and disease-specific interventions, including connecting members to educational resources and our integrated disease management programs described above. Our health coaching approach provides education, tools, and interventions to help individuals adopt healthy behaviors, identify triggers, manage symptoms, and decrease risk factors to manage chronic conditions and prevent ED visits. Our CHWs help members set up remote patient monitoring tools and other devices that promote independence, such as ConnectionsPlus phones that allow members to connect with their PCP and other providers, Care Managers, CHWs, or Health Coaches and access mobile tools such as myStrength and Krames (see below).

Member Engagement and Health Literacy Tools. Nebraska Total Care offers a suite of tools and resources to equip our members to actively engage in their care. Our written materials, member tools, and verbal communications are accessible and easy to read, helping to promote health literacy and encourage member adherence to care guidelines. Supporting our

members in leveraging available information and tools are CHWs, Member Services, and other Care Management staff.

24/7 Nurse Advice and Behavioral Health (BH) Crisis Lines. Nebraska Total Care's 24/7 NAL is a valuable, consistent, and trusted resource for members and families concerned about health issues and seeking immediate advice. Our licensed nurses can help members quickly understand their health issues and make educated decisions about visiting an ED or urgent care, treating at home, or making an appointment with their Primary Care Provider (PCP). ***Nebraska Total Care exceeds contract requirements by providing access to qualified nurses beyond business hours.*** This service helps reduce avoidable ED visits, directs members to more appropriate levels of care for their situation, and promotes education and self-care for issues that can be treated safely treated at home. ***In 2021, our 24/7 NAL received 1,863 calls, of which 35% were clinical.***

Nebraska Total Care in Action

Our nurses safely diverted 39% of 24/7 NAL callers who thought they should go to the ED to more appropriate lower levels of care—saving Nebraska Medicaid roughly $23,000 in inappropriate ED costs.

Nebraska Total Care's 24/7 BH Crisis Line is a hotline for members experiencing a BH crisis and for family and caregivers supporting a member in crisis. The goal of our crisis line is to provide an immediate access point to a BH clinician, who uses their clinical skills to de-escalate a crisis, establishes a safety plan with the member, and then connects the member to BH care to address immediate and ongoing needs. Our BH clinicians help stabilize members in their homes and keep them from unnecessary and often stressful or long-distance trips to the ED. In 2021, our24/7 BH Crisis Line received 3,372 calls. Our BH clinicians were able to provide immediate support for 95% of members, keeping members safe at home and connecting them to BH resources and services. For the 5% of calls that were true crises, we activated emergency medical services to support the member and connect them to immediate care.

Krames Health Library. Individuals with low health literacy may avoid going to the doctor for easily treatable injuries or conditions, leading people to go to the ED more often than they need to. In other cases, low health literacy or confusing medical information can cause people to not appropriately adhere to medical instructions, including taking medicines as prescribed or attending follow-up visits. The Centers for Disease Control and Prevention estimate that nine out of 10 people struggle to understand medical information when it is not provided in simple language.To increase health equity, promote health literacy, and help members fully participate in their health care journey, Nebraska Total Care offers access to the Krames Health Library as a health resource for members. Krames is a comprehensive online health library which contains evidence-based, peer-reviewed information on over 4,000 health-related topics in simple, straightforward languages. The health library, which is accessible in multiple languages and searchable by topic or keyword is easy to navigate and includes books, health sheets, and a comprehensive drug reference guide.

Proven BH Results

After our 2021 email campaign promoting our Digital BH Platform, more than 720 members enrolled ***with roughly 39% demonstrating clinical improvement within six months.***

myStrength. The COVID-19 PHE highlighted the need for self-care resources to improve mental health and overall well-being for members experiencing BH conditions. Our Digital BH Platform fosters personal responsibility and healthy lifestyles by enabling members to learn more about their diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. Members can engage in personalized e-learning programs to help overcome BH conditions such as depression, anxiety, overuse of drugs or alcohol, and serious emotional disturbance in a safe, confidential environment. We also encourage caregivers to utilize our Digital BH Platform, myStrength, for their self-care or to better understand the BH diagnosis of their child or family member.

Digital Wellness Support Program. Wellness programs are shown to increase positive, healthy behaviors among participants. Wellness programs provide health education and disease self-management tools. They can also help motivate people to take charge of their health behaviors. Nebraska Total Care's Digital Wellness Support Program includes a wellness assessment that allows members to complete an interactive appraisal of their health and wellness. A report is generated for their use regarding their current health, including strengths and areas for improvement. Members can then use interactive health tools, education materials, and links to more information to start making positive behavior changes. Wellness topics include physical activity, nutrition, weight management, stress management, quitting smoking, safety and prevention, and depression.

Findhelp Community Resource Platform. Nebraska Total Care's Findhelp is a searchable database of vetted and regularly updated health and wellness resources. Findhelp, available in numerous languages, helps connect members to local

programs and resources that best fit their needs, including housing, transportation, financial assistance, food pantries, and other social resources by zip code. Resources are updated immediately when our partners have new information to share. The full database is validated semi-annually to ensure quality, increasing the likelihood that members are satisfied with the tool and will continue using it to improve access to SDOH resources.

Care Management Resources. Our Care Management staff promotes a coordinated, proactive, disease-specific approach to improve self-management and clinical outcomes. As indicated, we complete a disease-specific assessment and provide disease-specific education, support, and condition monitoring. CHWs and Care Managers help members actively and effectively participate in their care; adhere to their recommended treatment plan; identify precipitating factors and appropriate responses before they require more acute intervention; and understand the appropriate use of resources needed for their care. Members achieve improved health outcomes as a result of their commitment and our support. "Donna," for example, lost 18 pounds, decreased her insulin dosage, got her HbA1c levels under control, and feels much better due to nutrition and exercise coaching with her diabetes health coach. ***In addition, aggregate utilization changes from 2018 to 2021 have demonstrated a positive impact, including a 32.4% decrease in inpatient admissions, a 29.4% decrease in potentially preventable admissions, and an 8% decrease in potentially preventable ED visits, indicating more appropriate utilization of preventive services.***

Member Incentives. My Health Pays is our member incentive program that offers financial rewards to members actively engaged in healthy behaviors and decision-making based on local trends, MLTC priorities, and past performance. Eligible members can earn rewards for completing annual preventive health visits and other recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. My Health Pays rewards can be used to cover payment for childcare, telecommunications, utilities, education, rent, and transportation services, in addition to eligible purchases at any Walmart store. The following outcomes were attributed to engagement in our incentive program from February 2020 to February 2022:

- 19.7% increase in flu shots
- 49.6% increase in infant well visits
- 52.2% increase in child well visits
- 113.2% increase in cervical cancer screening
- 2000% increase in diabetes comprehensive care
- 103.7% increase in breast cancer screening
- 110.2% increase in Annual PCP visits

SDOH, Including Risk and Protective Factors for BH Concerns

As described above and outlined in **Figure 51.H** below, we look beyond the presenting concern to get a big-picture view of the individual in their environment to address the needs of families and communities.

Figure 51.H Nebraska Total Care Identifies SDOH Needs and Risk Factors for BH Concerns.

SDOH KPI Dashboard. Our Health Equity and Diversity Committee, described previously, aligns its work with the Healthy People 2030 Framework, reducing disparities through access to SDOH resources. The group reviews data from our SDOH Key Performance Indicator (KPI) Dashboard to craft innovative solutions that meet the needs of the rural, frontier, and urban Nebraska communities. For example, our Fork Farms rural food insecurity project, described further in this response, is a result of data gathered by the SDOH KPI Dashboard.

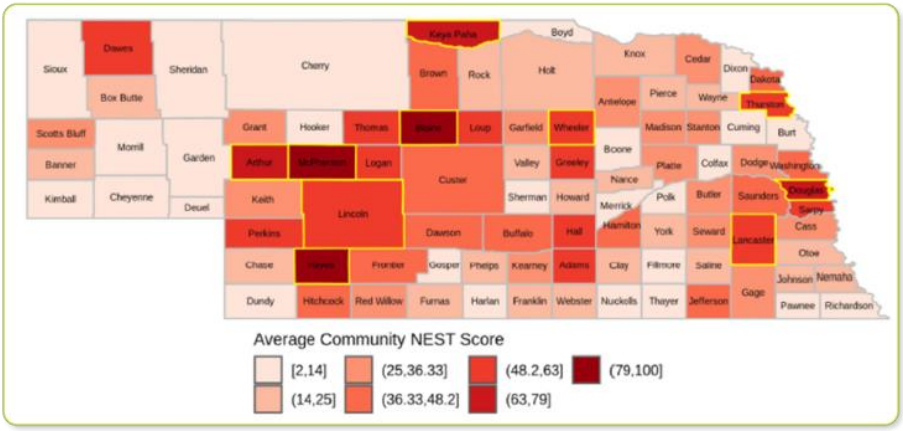
Powered by our Centelligence reporting and analytics platform, the SDOH KPI Dashboard aggregates SDOH data from claims and assessments to analyze member patterns and trends in social barriers to care. The Dashboard shows SDOH screenings completed by month and members with SDOH needs by category (employment, housing, education). The Dashboard allows users to assess cost and utilization metrics by SDOH-need category. For example, users can view the average PMPM costs or ED visits for members facing housing barriers. The Dashboard also allows users to analyze clinical conditions and SDOH needs by population segments such as age, race/ethnicity, and gender. **Figure 51.I** shows our SDOH Dashboard.

[redacted]

Identifying SDOH Needs. Nebraska Total Care recognizes that members' social needs constantly change and that SDOH impacts overall health and BH. To ensure we address member needs as they occur. ***For example, in response to the national baby formula shortage, Nebraska Total Care was able to secure 15 canisters of baby formula which we delivered to Tribal communities, ensuring members are able to adequately feed their babies***. We screen members for SDOH needs at every member contact and collect, aggregate, and synthesize SDOH data from a variety of sources, including:

- **Neighborhood, Economic, and Social Traits (NEST) Predictive Model.** NEST, shown in **Figure 51.J**, identifies the most significant SDOH factors influencing health care utilization at the individual and community levels. NEST is a predictive model that uses member and public data sources to predict member-level risk attributed to social factors. NEST can hotspot communities with high needs; each census tract level in Nebraska receives an aggregate SDOH opportunity score in NEST. We can overlay member data (claims, utilization, assessment/screening, demographics) and provider (specialty, office location, provider panel) composites to measure the opportunity for impact.

Figure 51.J NEST Data Informs Targeted Interventions.



- **Z Code Utilization Dashboard.** The dashboard allows us to view national trends, drill down to the provider level, and assess SDOH categories regarding the utilization of ICD-10 billing codes related to social needs.
- **HRS and HRA.** We assess SDOH needs within the HRS as part of the new member welcome call, and Care Management staff assesses SDOH gaps during every member interaction. We use this data to stratify membership based on the level of risk, allowing greater insight into existing disparities and factors that may contribute to inequities.
- **SDOH Mini-Screen.** The SDOH Mini-Screen is a member-centric tool to identify changing SDOH needs rapidly. This seven-question screen identifies needs such as food, housing, utilities, transportation, safety, employment, and social

support. It allows our team to identify members' prioritized needs, develop interventions to remove barriers, and quickly drive the greatest impact. Members can complete the SDOH Mini-Screen at any time on our secure Member Portal, Findhelp, or through a call to the member call center or with our Care Management staff. Member Service Representatives (MSRs) refer members to complete the Mini-Screen online. MSRs are trained to recognize members presenting SDOH needs and provide an immediate referral to Care Management who will provide specific recommendations and introductions to community resources. Additionally the IVR will include three SDOH questions that refer members to Care Management if needs are identified. Nebraska Total Care is launching an innovative program to incentivize dentists to proactively screen for social needs. ***We will offer a financial incentive to dentists to complete a tailored version of the SDOH Mini-Screen with their members.*** Dentists will submit the information via the Provider Portal, which will cue Care Management staff to follow up with the member.

- **Stakeholder Feedback.** We work with external stakeholders to understand community SDOH needs and resources at a population level. We identify immediate and emerging needs from our community network. We receive continuous feedback through our Member, Community, and Provider Advisory Committees; our Health Equity and Diversity Committee; provider engagement meetings; member/family feedback; and digital interactions.
- **Information from Key Community Partners.** We currently have over 3,000 partnerships with organizations throughout Nebraska to address SDOH needs, including Heartland Family Service and Family Housing Advisory Services, Inc., enabling us to quickly connect members to resources. Nebraska Total Care uses information from these key community partners to identify and address additional needs within the membership and the broader community. We use information from Findhelp to identify what members are searching for and the organizations they are connecting with. Data from Findhelp shows, for example, that the top five most engaged organizations are Nebraska Department of Health and Human Services (DHHS) - Energy Assistance; Nebraska Department of Economic Development - Emergency Rental Assistance; Heart Ministry Center - Case Management Services; Douglas County General Assistance Center - General Assistance Program; and Stand Up Wireless - Stand Up Lifeline Wireless – Free Wireless Service. Knowing this, we work to ensure our Care Management program is addressing these needs and making timely connections to these programs.

SDOH Pay-for-Performance (P4P) Program. Nebraska Total Care is establishing a P4P program as part of our overall value-based contracting approach. Through the SDOH P4P program, providers will administer a two-question evaluation tool (Hunger Vital Sign), based on the US Household Food Security Scale, to identify children in households at risk of food insecurity. To identify homeless or under-housed members, providers will administer a two-question Housing Screener adapted from the CMS Health-Related Social Needs Screening Tool.

If a member is identified as food or housing insecure, the provider will submit diagnosis codes such as Z59.0 (Homelessness) or Z59.1 (Inadequate Housing) to receive an incentive payment. Once we evaluate the program's initial results, we will consider adding on other layers to promote closed-loop referrals. Providers will refer members with identified needs to a community-based organization to address their needs and document referrals in Findhelp to complete a closed-loop referral. Providers will notify our Care Managers when they identify that a member is at-risk for SDOH barriers, facilitating member outreach to connect them to community resources and support.

SDOH P4P Program

Nebraska Total Care will offer a financial incentive to targeted providers for evaluating members' risk for food and housing insecurity, submitting appropriate SDOH screening and ICD-10 billing Z codes with the claim.

SDOH-Specific Training. SDOH training gives special attention to the impact of health disparities and health inequity, including referral sources and how to facilitate closed-loop referrals. Staff complete training on how to connect members with housing assistance and shelters, food banks and pantries, educational and job opportunities, organizations that assist with and address physical and/or sexual abuse, and transportation. We train all member-facing staff on the impact of SDOH on members' health and wellness. Training includes issues related to housing, education, food, physical and sexual abuse, violence, health care disparities, and cultural diversity. Our onboarding and training programs include Unnatural Causes training and Person-Centered Thinking, which help staff recognize social barriers and strategize effective interventions.

Addressing Social Isolation. Social isolation is worse for health than obesity, the equivalent of smoking 15 cigarettes a day, leading to increased re-hospitalization risk. Nebraska Total Care data analysts have access to a clinically-validated predictive model enabling us to identify members at risk for loneliness and social isolation. Our proprietary algorithm uses member-level data, including member demographics, diagnoses, and claims history. Once we identify a member at risk for loneliness, we conduct outreach to screen the member and engage them in the appropriate program to fit their unique goals and needs. Our ***Friendly Voices Program*** connects local community-based volunteers with Nebraska Total Care members identified as being at risk for social isolation. We focus on direct interpersonal interactions and connections with

our members. Community volunteers call program participants to engage in ongoing friendly calls with members who would like more social contact. The goal of the Friendly Voices Program is to reduce feelings of loneliness or social isolation, increase social connectedness, provide a safety check for members identified as experiencing social isolation, and create meaningful connections across the community.

As another example, we assess the member's caregivers for signs of stress and connect the caregiver (or the family unit as a whole) to community-based support. This attention to the BH needs of the whole family is a focus of our Caregiver Support Program, highlighted on our website. Our program offers a variety of tools to caregivers, including a caregiver assessment, education resources, a caregiver journal, and a connection to community-based support. Our Community and Disability Liaison is an active participant in the Caregiver Coalition, which informs our overall Caregiver Support program.

Local Community Involvement. We focus our person-centered approach on the whole health of individuals and leverage our strong local community involvement and leadership. Staff from all levels of our organization play active roles in the community agencies that serve members. For example, many of our leadership staff participate on nonprofit Boards. We participate in joint learning opportunities with community-based organizations such as Friendship Housing, Cedars Transitional Youth Program, and the Volunteer Lawyer Project. These meetings are an opportunity to share information and streamline referral processes. Through these relationships and the relationships established by Care Management staff, we gain a better understanding of the challenges members face and connect them with quick access to the resources needed to support them. We take the time to understand each member's goals and barriers and facilitate appropriate resources and follow-up as part of our overall health equity and Care Management model.

National Expertise. Informing local solutions, we leverage resources from our parent company. Centene has a web-based repository, Outcomes Improvement Central (OIC), which catalogs all population health programs deployed across the enterprise. Centene's OIC enables its affiliate health plans, such as Nebraska Total Care, to view programs enterprise-wide, access program evaluations, and learn about program and study design. Our affiliate Medicaid health plans share evidence-based best practices on our ***National SDOH Champions Team*** call.

Identification and Tracking of Members Needing a Higher Level of Care Management Services

Early identification of individual needs paired with timely access to necessary services is key to improving or maintaining member health, functioning, and wellness. Our PHM framework ensures our Care Management program and interventions are relevant and customized. Our stratification model and predictive modeling tools introduced here and further described in Question V.L.52 below inform the types of programs members need and the appropriate resources, tools, and staff required. We continuously use data to identify improvement opportunities and develop or modify programs, interventions, and staffing to target resources and generate the highest impact.

Identification. We use a combination of methods and tools to identify individuals that may benefit from Care Management services, including members with special health care needs: eligibility and enrollment data; screenings and assessments; current and historical claims, authorizations, and utilization trends; State, staff, provider, and member self-referrals; and Care Management reports. Our model considers a member's PH, BH, dental health, and SDOH needs using claims and referrals; pharmacy data; lab results; assessment findings; Notification of Pregnancy forms; demographics; socioeconomic indicators; census; and racial, ethnic, geographic, and SDOH identifiers, including over 200 external SDOH data elements. Third-party data sources informing our model include the CDC Social Vulnerability Index, American Community Survey, Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, School Performance Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System. These curated data sources create a geo-demographic and risk profile for each member indicative of the level and type of Care Management resources needed.

98% Predictive Accuracy Rate

Our Readmission Prevention Model assigns a probability of readmission by member at the time of acute inpatient admission to assist discharge planners and CMs with prioritizing their post-hospitalization outreaches. This model has a positive predictive accuracy rate of 98% and maximizes efficiency of Care Management outreach by directing resources to those members most in need.

We use targeted predictive models described in **Question V.L.52** below to identify potential risk factors related to SDOH, SUD, diabetes, ED visits, readmissions, and other defined categories. For example, our Opioid Risk Classification Algorithm stratifies members at-risk for substance misuse and abuse, before a diagnosis, using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. ***Since the inception of this model in 2017, the identification of members with opioid use disorder has increased by over 150%.***

Tracking. We provide our Care Management team with a biweekly Care Management Prioritization report for ongoing tracking of members with potential Care Management needs. This tool identifies and prioritizes members for Care Management, including members needing a higher level of Care Management. The Care Management Prioritization report generates a profile for each member highlighting key information, including their risk for a variety of adverse outcomes or inappropriate utilization(such as diabetes, ED use), the likelihood of engagement, Care or Disease Management status, and predicted future utilization. ***We use this tool biweekly for our entire membership to identify changes in severity or acuity.*** As members move through the continuum of severity (either up or down), we reassign them to the most appropriate level of Care Management.

Care Plan Oversight. Members' needs are fluid and change over time. As part of our Care Management model, our Care Managers are actively monitoring care plans to ensure members are making progress toward care plan goals. As part of this oversight, during every contact Care Managers assess for any change in condition that might necessitate a change in level of Care Management services and support. This is in addition to systematic monitoring such as ED visits or inpatient admissions.

When determining a member's risk stratification, we consider current and historical factors, including acuity of chronic conditions, BH disorders, maternal health risk, inpatient or ED utilization, SDOH, and safety/risk factors, as shown in **Figure 51.B** above**.**

Ongoing Monitoring. Members move between levels as their risk, acuity, needs, and preferences change. Our person-centered approach to risk stratification relies on information we directly learn or validate from members, including their priorities and readiness to change. We use leading indicators, such as admissions, discharge, and transfer data, to re-stratify members in real-time and ensure we continuously provide the most effective level of support. For example, we are developing a Foster Care Dashboard to understand better the needs of members engaged with the Department of Children and Family Services. Our ***Homelessness Report*** identifies members who are experiencing homelessness. We then engage our dedicated Housing Team, consisting of social workers, CHWs, and our Community and Disability Liaison, to aid these members.

Case Studies Addressing Community Differences in Our Care Management Approach

Nebraska Total Care has a long history of working with different communities representing different geographies, cultures, races/ethnicities, sexual orientations, and socio-economic circumstances. Through this work and local partnerships, we have collaborated on programs and solutions that have directly impacted members with specialized needs. We offer the following program descriptions and case studies illustrating how we address community differences through our Care Management approach.

Nebraska Total Care CHWs. Using our NEST tool, Health Equity Dashboard, and SDOH KPI Dashboard, we strategically deploy CHWs in the areas of greatest need to reduce disparities and improve health outcomes. CHWs adapt their approach to the specific needs of each community in which they work. Our CHWs meet with members in their homes or in the community to provide culturally relevant face-to-face support. Our CHW programs include:

- **Tribal Support.** We have a team of trained CHWs to support Tribal needs. Our CHWs have completed a 50-hour Member Connections Community Health Training and are culturally adept and locally-based across Nebraska. CHWs support members through outreach, education, referrals, Care Coordination, and one-to-one visits.
- **Diabetic Health Coaching.** We provide health coaching for adult members with Type 2 uncontrolled diabetes, particularly in communities with health disparities. CHWs educate these members on nutrition, exercise, and the disease itself to improve self-management skills and lifestyle changes. The program reduces the member's Hemoglobin A1c, decreases the member's weight, and works toward medication adherence and regular visits to their PCP/specialist. CHWs work with members on SDOH needs at every visit.
- **Perinatal Health Coaching.** We provide perinatal health coaching to pregnant members with a special focus on moderate and high-risk members to reduce maternal and infant health disparities. CHWs provide targeted interventions and education to support positive health outcomes for both the pregnant member and the baby during pregnancy and postpartum. The program supports connection to prenatal care and NICU reduction. CHWs educate

Coordinating with Tribes

We met with the Ponca Tribe to develop Care Management community support worker processes and community diabetic Care Management. We integrated feedback into our processes, provided tailored resources, and began Diabetic counseling sessions for members with high risk factors – ***resulting in a 34% increase in tribal services and Care Management.***

members and assist with SDOH needs.

- **Targeted Member Outreach.** Nebraska Total Care partnered with a provider-owned mobile mammogram bus to bring mammograms closer to members who needed screening. Our team assisted with member outreach to encourage members to sign up for the mobile mammogram bus to close the breast cancer screening care gap in certain zip codes.

Community Impact. CHWs are fulfilling our mission of transforming health one person at a time.

Meet "Sara." A Nebraska Total Care CHW called Sara for a health coaching session. During the discussion, the CHW discovered Sara was living in an unworking vehicle with her adult son. At that moment, a blizzard with a predicted 10 inches of snow was only hours away from Sara and her son, and they did not have safe alternative shelter from the storm. The CHW immediately shifted focus to finding the family shelter. Knowing that community partners would likely be closing soon for their own safety, the CHW enlisted the help of the entire available Care Management team to begin making calls to find assistance. The team identified both an available motel room and a community organization to fund the room. The CHW then arranged transportation to pick up Sara and her son and take them to the motel, ensuring they were safely housed ahead of the storm. After the immediate crisis had passed, the CHW worked with Sara both on her diabetic care and a more permanent housing plan.

Meet "Debra." Debra is a 64-year-old female identified as having an HbA1c of 8.5 on a member report. Her high A1C triggered a referral to our Diabetic Coaching program that our CHWs follow. Allie, one of our CHWs, outreached to Debra and explained the benefits of our diabetic coaching program. Debra admitted that she was ready for a change and agreed to enroll in the program.She also expressed her desire to join a gym. Allie shared that one of our value-added services is a membership to the YMCA and assisted her with getting a membership. Trained in person-centered thinking, Allie engaged Debra in ongoing conversations, and the two developed a great rapport. Allie and Debra worked together to establish health goals to include provider recommended reduction of insulin, weight loss, and lowering her A1C level. Allie further assisted Debra in creating small steps to live a healthier life by introducing proper nutrition and physical activity. While working with Allie in the diabetic coaching program, Debra received a Continuous Glucose Monitor (CGM). The ease of monitoring her blood sugars through this device, provided her more consistent blood sugar results and gave her the ability to make more informed decisions on how to balance her food and physical activity. Debra has been a diabetic for 17 years. Within three months of being in the diabetic coaching program, Debra lost 18 pounds, lowered her A1C by 2 points, and decreased her insulin dose. She has consistently improved her health and expresses that she feels better every day. Debra decreased her 300 initial insulin units down to 93 in the morning and 50 in the evening. Allie continues to work with Debra, supporting her in reaching her ongoing health goals.

Meet "Anne." Anne was identified for Care Management support through our "No Notification of Pregnancy" report. At the time of initial outreach, Anne was just over a month along in her pregnancy. Anne had an established OB provider and a history of miscarriage just four months prior. Anne was provided information on Nebraska Total Care's Perinatal Health Coaching Program, agreed to participate, and was assigned to our CHW Lexi in Anne's service area. Lexi scheduled her first visit with Anne at Anne's home. Upon arrival, Lexi focused on building rapport to establish trust. Anne was very receptive to Lexi and quickly began disclosing the anxiety she was experiencing with this pregnancy due to her recent miscarriage. Lexi was able to empathize with Anne and validate her feelings. Lexi shared her experience with miscarriage to relate with Anne on how she was feeling. This seemed to make Anne comfortable, and she began talking even more about her feelings and concerns and discussed that she was experiencing cramps which increased her worries. Lexi asked Anne to write down some questions to bring up at her next OB appointment so she would remember them when she saw her doctor. Lexi discussed social needs with Anne and confirmed she had already been in contact with the WIC office. Lexi informed Anne of some future educational topics they would go over and let Anne pick some that she desired to discuss. Anne was most interested in how her body will be changing with the pregnancy, nutrition during pregnancy, and how to cope with the emotional and hormonal changes she is experiencing. These topics were covered during future visits, supporting a healthy birth outcome.

Looking Forward: Enhancing CHW Services through Pathways HUB. Building on national best practices and affiliate experience in implementation, ***Nebraska Total Care is part of the core team that is working to bring a HUB entity to Douglas County, which has high rates of health disparities.*** The Pathways Community HUB model is an evidence-based, outcomes-payment care model based on confirmed risk mitigation. The HUB's Pay-for-Performance service-delivery model improves health outcomes by developing a pathway to remove barriers to care, assist with SDOH, and attach individuals to primary and specialty care. The HUB model enables partners to share resources, data, and administrative functions through a centralized process, whereby the HUB holds all contracts with payers and community-based organizations. Focused first on maternal and infant health, the HUB will provide support and education and use life experience to help connect members to community resources through trained CHWs.

Community Impact. For one of our affiliates, the HUB produced a return on investment of $2.36 for every $1.00 invested. High-risk mothers in a community HUB service area where the member was not exposed to any community HUB activity were 1.55 times more likely to deliver a baby needing Special Care Nursery or NICU care when compared to h igh-risk members who received HUB services through delivery. As part of the program, our affiliate invested directly in the most at-risk communities with payments to agencies and CHWs through the Community Pathways HUB model, reimbursing for over 150 elements of activity to meet member needs. Investments that address non-clinical barriers demonstrated a positive impact on both quality and cost outcomes. Active use of Community Hubs combined with traditional health plan care management to reduce non-clinical barriers to care resulted in a lower total cost of care in a baby's first year of life.

Example Services Available through Pathways HUB Investments

- *Legal assistance*
- *Housing, utilities assistance*
- *Transportation assistance*
- *Childcare*
- *Parent education*
- *Linkage of pregnant mothers to needed social services and supports*

Start Smart for Your Baby (Start Smart). Our national award-winning Start Smart, launched in 2008, has resulted in numerous papers, academic posters and presentations that contribute to the care of pregnant Medicaid recipients across the country today. Start Smart serves as the umbrella for all of our perinatal care coordination efforts, inclusive of Care Management and complex case management with interventions tailored to the member's unique needs. Nebraska Total Care understands that multiple factors impact health outcomes, and engaging members in the right type of care is the first step in addressing these factors. Care Management staff reach out to pregnant members to educate them about Start Smart benefits, including incentives, and engage them in prenatal care. Staff help members select an appropriate primary care, dental, women's health, and OB/GYN provider, as well as connect them to postpartum care and resources that address SDOH needs. We facilitate communication between providers involved in the member's care to promote a healthy birth and quickly address and identify medical, behavioral, or social risks. Brought to Nebraska in 2017, Start Smart has continued to evolve through new and improved programs targeted for members with special needs or identified health disparities. For example, addressing disparities in prenatal care for Black and Hispanic women through targeted outreach, interventions, and staff hiring, including recruiting Spanish-speaking Care Managers.

Addressing Maternal and Child Health

Advancing Health Equity

Nebraska Total Care is reducing health disparities in prenatal care:

- 17.1% increase in the average number of prenatal visits made by Black members from 2018 to 2021
- 13.4% increase in prenatal visits by Hispanic members from 2018 to 2021
- In 2021, we eliminated the disparity in NICU days between Hispanic and White members.

New for this Contract, through our partnership with Pomelo Care, pregnant Nebraska Total Care members will be able to receive virtual group prenatal care grounded in the evidence-based Centering Pregnancy model. Group prenatal care has been proven to reduce preterm births by 30%. With just two accredited Centering Pregnancy sites in Lincoln and Omaha[1], Pomelo's virtual model increases our members' access to this verified approach to reducing preventable NICU stays.

Community Impact. Start Smart has had a direct impact on our members' lives and advancing health equity in Nebraska (see Advancing Health Equity call out box). From new moms suffering from anxiety about caring for their infant to those with language barriers, Start Smart has a program and place for everyone.

Meet "Lea." Lea is a new mother to a baby girl. Post-delivery, a Care Manager reached out to Lea to check on her and the baby. Lea and her husband voiced frustration and concern that their baby was fussy and cried a lot. Using motivational interviewing, the Care Manager learned that the parents were feeling anxious as new parents even though the pediatrician said there were no health issues with the baby. Our Care Manager provided education on periodic developmental crying as well as coping measures for the parents and the development of a crying plan. The Care Manager emailed resources and video links for Lea and her husband to watch. Lea reported the materials were very helpful and they learned a lot about their baby's crying pattern. They started to feel more relaxed and confident in staying home with the baby and had a crying plan in place.

Meet "Maria." Maria was identified during her pregnancy and enrolled in our Start Smart high-risk pregnancy case management program. With the help of our Spanish-speaking staff and interpreters, Maria kept in touch with her Care

[1] "Centering Sites in Nebraska (NE)." Centering Sites for NE, https://centeringhealthcare.secure.force.com/WebPortal/ListOfCenteringSites?stateName=NE.

Manager regularly during her high-risk pregnancy. At her nine-month call, Jodi checked in to see how Maria was feeling and to make sure she was aware of the signs and symptoms of delivery. Jodi learned that Maria had been leaking fluid for four days but hadn't reached out to her doctor because as a Spanish speaker she had difficulty communicating with him. Jodi immediately arranged a doctor's appointment for Maria in Omaha. Upon examination, Maria's doctor detected that the amniotic sac had already broken and she was transported directly to a labor room. About an hour later, her healthy baby was in her arms. Because Maria was able to share important details about her condition with Jodi, she avoided a dangerous situation. Maria says, "It was a blessing she called me that day." Maria shared her story in Spanish on youtube, which was subsequently shared by The Mexican Consulate in Omaha. There have since been 3,800 views of the video, demonstrating the resonance of this experience within the community.

Specialized Care Management Programs. Based on the needs of Heritage Health members, Nebraska Total Care continues to develop and enhance our Care Management programming to meet diverse member and community needs. Specific populations of focus include members experiencing homelessness and other SDOH needs and members with SUD. Part of our Care Management team, Nebraska Total Care's dedicated Housing Team, consisting of social workers, CHWs, and our Community and Disability Liaison, focuses on housing stability and addressing underlying issues such as substance use and SMI that contribute to chronic homelessness. We partner with a broad network of shelters and agencies supporting members experiencing housing instability throughout the State, including housing continuums of care such as the Metro Area Continuum of Care Homelessness and the Lincoln Homeless Coalition. Our Community Liaisons and Outreach staff are in the community helping to identify and connect members to reliable SDOH resources to address all of their social needs, including housing, food insecurity, transportation, education, domestic violence, and isolation. Our specialized team of SUD Care Management staff, including Licensed Alcohol and Drug Counselors, offers holistic support for members with comorbid SUD.

Community Impact. Through our specialized teams, expertise, and predictive modeling tools, we have improved outcomes for members with complex needs.

Meet "James." James had a lack of stable housing, mental health instability, and unaddressed PH needs. He was experiencing homelessness, he was difficult to engage through Case Management outreach, and he had multiple inpatient psychiatric hospital stays and emergency department visits. Care Management outreached to James' mother to assist with the coordination of his care. James was on a waitlist for DD services, and our Liaison coordinated a meeting with DDD and James' mother. DDD determined James was eligible for emergency DD funding based on his needs and ongoing homelessness. They approved his placement at an independent living home. Due in part to his current stability with placement, James has ultimately been able to address long-overdue PH needs and has participated in vocational rehabilitation and BH therapy.

Meet "Lara." Lara had been homeless for at least two years, staying in unsafe environments and having to rely on others for basic needs. Lara had not had insurance until Medicaid Expansion and therefore had gotten into the habit of relying only on the ED for her medical and BH needs. Consequently, many of her health care needs had gone unmet. Lara struggled to work with community supports and due to illiteracy, it was difficult for her to access community resources as many of them required completing paperwork. Over this past winter, Lara was asked to leave a home she was utilizing to sleep in and found herself living under a bridge by the shelter in Lincoln. Lara was encouraged by our Program Specialist to stay in the shelter for her safety and to stay warm, however, she refused. Eventually, all of her things were stolen, including the tent she used for shelter, her cell phone, and the sleeping bag she used to stay warm. At that point, Lara reached out to her Program Specialist in tears. Lara said she had no coat or outdoor gear and didn't know what to do anymore. The Program Specialist called the shelter in Lincoln and was directed to CenterPoint's Street Outreach Program. Lara had been directed to contact them several times regarding their rehousing program but was afraid to go in due to COVID concerns. Now, the street outreach program was able to go to her and enroll her in their program. After ensuring her safety over the weekend, CenterPoint began the process of qualifying Lara for their housing program. As of April 2022, Lara is living in a trailer with the rent and utilities funded through a grant. Lara is slowly acquiring things for her new home and is mending relationships with her mother and daughter and reports they have even given her some housewarming gifts. Lara has established care with a PCP and is working with Family Services of Lincoln and has a support worker that meets with her weekly.

Meet "Joe." Joe loved his career as a truck driver until a series of strokes uncovered kidney disease. Joe was seeing several doctors, attending daily dialysis, and struggling with anxiety over his new conditions and losing his livelihood. Because he lived in a rural community, travel to providers was a challenge and he began to frequent the ED for care. Our Care Management team reached out to Joe to help coordinate his care and discovered Joe could no longer afford his cell phone. The Care Manager helped enroll him in our ConnectionsPlus program so he could communicate more efficiently with his doctors and Nebraska Total Care. Joe's doctors now work together and he has the medicines he needs at home to prevent

unnecessary trips to the ED. He can also contact his providers and use Nebraska Total Care's digital health and wellness tools to maintain his health and wellbeing. Joe has less anxiety and feels more confident in managing his health.

Meet "Ted." Ted was identified as needing Care Management (CM) on our SUD/AUD member report. Daniel, one of our Care Managers with expertise in BH attempted an initial unsuccessful outreach to Ted to discuss what CM could offer him. After a week of monitoring, Daniel learned that Ted had admitted to the hospital for an inpatient stay related to complications of withdrawal. Daniel outreached to Ted while he was in the hospital. Ted was motivated to participate in CM. Daniel updated Ted's contact information so that he had a current phone number to outreach to upon discharge from the hospital. Ted expressed that he had been suffering from ongoing pain as a result of spraining his ankle about a year ago and may need a walker or cane to assist him in walking, his primary mode of transport. Daniel explained available transportation benefits to get Ted to his medical appointments. Ted shared with Daniel that he did not have a PCP identified and was assured we would assist him with identifying a PCP that best fit his needs as well as providers for dental, vision, mental health, and psychiatry as needed. Daniel reviewed Ted's care gaps in TruCare Cloud and noted that Ted needed a flu shot and annual physical and made plans to schedule post discharge. Daniel spoke to the hospital discharge planner to collaborate on discharge planning and any barriers that were identified that he could assist with. During their next meeting while Ted was still in the hospital, Ted mentioned that he was interested in losing weight. Daniel provided information on the Weight Watchers value add service that Nebraska Total Care offers and wrote the goal down for Ted to share with his PCP. Upon discharge from the hospital, Ted went to a residential treatment program where he could further work on his goal of sobriety. Ted obtained a PCP and he continues to work with Daniel to support his ongoing health goals.

52. Describe the Bidder's approach for identifying members in need of care management services, including:
• The proposed process for providing a health risk screening to all members upon enrollment to identify and assess members potentially eligible for care management services.
• A description of the algorithms and methodologies the Bidder will use to identify members potentially eligible for care management.
• The proposed process for conducting health risk assessments for members identified as potentially eligible for care management, including those who have or are likely to experience catastrophic or other high-cost or high-risk conditions. Submit the proposed health risk assessment template that the Bidder plans to use.
Page Limit: 5 Excluding the example risk assessment

Identifying Members in Need of Care Management Services

Early identification is a fundamental aspect of our Care Management model. Nebraska Total Care has a strong record of screening and assessing each member, including those with chronic and complex conditions, functional and habilitation needs related to disability, mental health, substance use issues, and Social Determinants of Health (SDOH) needs. Since starting our operations, we have demonstrated the ability to meet timelines for conducting initial assessments and complete more comprehensive risk assessments for individuals requiring a higher level of Care Management. We have established systems, policies, protocols, and capabilities to assess members' clinical, behavioral, functional, and social needs, determine the need for Care or Case Management services, and provide appropriate follow-up, referrals, and interventions.

High Touch Member Outreach

Nebraska Total Care uses multiple modalities of outreach including telephonic, email, text, targeted digital ads, and CHW contact within the first 90 days to promote completion of the HRS. ***This has resulted in a 249% increase in HRS completion since 2019.***

Our initial screening process includes a review of information obtained from completing the MLTC Health Risk Screening (HRS) tool, available claims data, health information exchange (HIE) data, and medical records. It also includes real-time methods for identifying members that need screening, including Nurse Advice Line calls and referrals from members, providers, and community partners. Integral to our model today, we use the initial screening process to:

- Review the member's clinical history and medications and identify Physical Health (PH), Behavioral Health (BH), functional, dental, and SDOH needs
- Identify the member's immediate needs, language and communication preferences, and accessibility requirements
- Stratify the member into the right level of Care Management, with immediate referral to a Care Manager, if needed
- Understand the member's self-identified goals, strengths, desired outcomes, and preferences

Providing an HRS to All Members Upon Enrollment

As part of our new member onboarding process, we will conduct outreach to 100% of new members to complete the HRS tool, including MLTC-defined HRS questions. The HRS helps us determine members' Care and Case Management needs. We aim to complete the HRS within 90 days of enrollment into our health plan through multiple modes of outreach.

Methods to Complete the HRS. Through experience, we have learned that successfully reaching new members to complete the initial HRS and other health assessments requires repeated attempts using multiple strategies that honor members' preferred modes of communication. Our no wrong door approach leverages various methodologies to successfully engage members in completing their HRS. On average, 13% of members complete their HRS through the secure Member Portal and 58% complete it with assistance from our Care Management team.

We attempt to complete the HRS during each member contact until completion. We take a proactive approach to complete the HRS during every member interaction, not stopping attempts after the initial 90 days. We use our Member Care Compass program and engagement strategy to better understand members, how they prefer to engage with Nebraska Total Care, and how we can best support them through their health care journey. Member Care Compass drives an omnichannel experience so that we honor a member's engagement preference – such as email, text, phone, or in person – while optimizing messaging through all appropriate channels to engage members consistently. We are enhancing how we welcome members by offering an in-home visit and providing them with an interactive digital welcome experience with step-by-step instructions, direct links, and advice for making the most of their health care and creating a better HRS completion experience.

Our ***Member Care Compass program*** uses the following methods to ensure timely completion of an HRS by all members upon enrollment:

- **Welcome Packets.** Members receive an HRS form in their Welcome Packet. This allows members to conveniently complete the HRS and identify barriers and services they need. It supports Nebraska Total Care's ability to risk stratify

Members who may benefit from Care Management, Disease Management, or preventive care services.

- **Outbound Member Calls.** As part of new member onboarding, we proactively conduct outreach to members by telephone to complete the HRS tool. We have learned through member feedback and focus groups that some members do not realize Nebraska Total Care is their Medicaid health plan. In response, we now begin outreach campaigns with automated calls to members that explain that their Medicaid application has been approved, introduce Nebraska Total Care, and identify Nebraska Total Care as their partner in their health care journey. During this automated call, the member has an option to press "0" and speak with a staff person to complete the HRS immediately. If we are unsuccessful in our first outreach attempt, we conduct a live telephone call to the member. If we are still unsuccessful, we make a third call within one week of enrollment. We will continue our efforts to contact the member by phone at least weekly for up to 90 days or until the member completes the HRS. Members can also call our toll-free Member Services Call Center to complete the HRS tool by telephone with one of our staff.
- **Email Outreach.** ***We begin outreach to new members on day one of enrollment***. We recognize there are various methods to communicate and engage members. If we have an email address on file, we send an electronic new member packet and welcome email upon enrollment with Nebraska Total Care. We have valid email addresses for 51% of our existing membership, allowing us to engage with them electronically. The welcome email includes a new member checklist with the HRS as the first item and a link to the secure Member Portal where the member can complete their HRS. We follow up with a second email that includes instructions and information about the importance of completing the HRS. Members receive a reminder email weekly for up to 90 days or until they complete the HRS. Upon completion, the member receives a thank you email that advises them of the next steps and provides details about how to use the My Health Pays rewards they earned from completing the HRS.
- **Home Visits.** To increase our engagement with members and HRS completion, we will offer new members a welcome visit at their primary residence or in the community. This visit helps us address SDOH needs, review benefits, and complete the HRS with the member and/or caregiver. The visit includes translation services as needed and offers an additional opportunity to engage the member in services.
- **Community Outreach.** Members may complete the HRS in person with our field-based Care Management team and Community Health Workers (CHWs). CHWs and other staff plan and participate in events across the State each year, where members may complete their HRS. We also leverage partner organizations' and CHWs as an extension of our Care Management team to successfully engage members, meet them where they are in their community, and help them complete the HRS. This includes our strategic partnership with ***Best Foot Forward,*** which provides outreach to members who are difficult to engage, including those we are unable to reach by telephone. This partnership includes location services, assistance with HRS and Notification of Pregnancy form completion, and benefit education. ***Best Foot Forward has a 58% success rate in reaching members who are otherwise difficult to reach and assisting them with completing the HRS.***
- **Member Portal and MyNTC Mobile App.** Nebraska Total Care members can complete the HRS via our secure Member Portal and MyNTC Member Mobile App. If we identify incomplete HRS information, our Care Management team places a follow-up telephone call to the member to facilitate the completion of the HRS. If we are unable to successfully engage the member by telephone, we send a letter or secure email and facilitate contact through our Care Management team to complete the HRS tool.
- **Member Connect Stations.** Member Connect Stations consisting of self-service tablets will be available in select FQHCs, CMHCs, and homeless shelters. Self-service tablets offer another option to complete the HRS. The tablets will provide a way to access health education information, benefits information, and their secure Member Portal account.
- **Provider and Pharmacy Providers.** To locate members who are difficult to reach, we engage our provider partners, such as Primary Care Providers (PCPs) and pharmacy providers, who often have more current member contact information. We also use CyncHealth, the State's HIE, to collect up-to-date contact information and use this to contact and engage members to complete the HRS.
- **Social Media.** Nebraska Total Care meets members where they are – even online, as shown in **Figure 52.** We place targeted ads on Facebook and Twitter that include links to the secure Member Portal to complete the HRS using member email addresses. The ads remind them to act quickly to complete their HRS.

FQHC HRS Pilot

Nebraska Total Care will launch a pilot program with select FQHCs in Omaha and Lincoln to increase HRS completion and enhance the member experience. Using our self-service tablets, members may complete the HRS at the FQHC office.

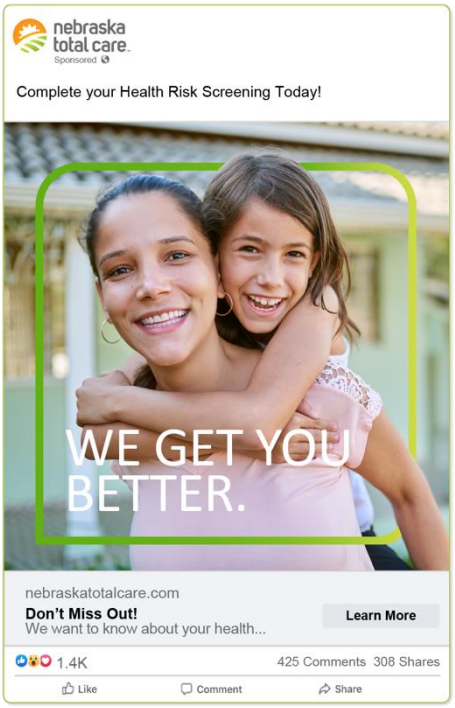
Using Algorithms and Proven Methodologies to Identify Members for Care Management

Our algorithms and predictive analytic tools are used to identify and assign Members to the most appropriate level of Care Management for their condition(s) and needs. Our Care Management model described in **Question V.L.51** above, includes four levels that drive the type, frequency, and intensity of Care Management services:

- **Healthy Engagement/Monitoring.** Focused on members with no recognized risk and members with moderate or high risk who decline Care Management
- **Low Risk.** Focused on intermittent or short-term coordination of care transitions
- **Moderate Risk.** Provides support to members with chronic or acute care conditions and SDOH needs
- **High/Critical Risk.** Serves members with complex PH, BH, and/or SDOH needs

These four service levels provide a comprehensive continuum of services tailored to each member's unique needs.

Figure 52
Reaching Members Where They Are.



Centelligence. Our Centelligence reporting and analytics platform uses proprietary algorithms and advanced predictive analytics to synthesize and analyze internal and external data inputs for the initial and ongoing identification of members for Care Management. This platform identifies and prioritizes members in need of Care Management services upon enrollment and throughout their tenure in Nebraska Total Care. This includes assigning members to the most appropriate level of Care Management and identifying members who are likely to experience high-risk or catastrophic conditions for Care Management outreach and intervention. Our evidence-based risk stratification algorithms systematically evaluate referral, enrollment, and eligibility information; laboratory data; medications; EHR and ADT data; screening and assessment responses; demographics; utilization management; PH, BH, dental, and pharmacy claims; prior authorization data; SDOH data; Notification of Pregnancy forms; data from publicly available sources such as the US Census and Immunization Registry; and historical fee-for-service data received from the State. Through these inputs, Centelligence's built-in algorithm assigns members a Care Management level, which helps us build a comprehensive risk profile and determine appropriate programs and interventions for each member to achieve or maintain optimal health.

Centelligence leverages data from a variety of sources, as described, applying advanced data science, machine learning, and analytic techniques to assess a member's risk for developing a particular disease or health outcome, or their likelihood of taking a certain action (e.g., engaging with our Care Managers). Centelligence allows staff to access tailored reports and dashboards, driving precision and clinical and administrative decision-making. We will continue to submit information regarding any new or revised stratification methodologies to MLTC for review and approval at least 90 days before implementation.

Care Management Prioritization Report. To make our risk stratification algorithm actionable, Centelligence generates a Care Management Prioritization report, which identifies and prioritizes members for Care Management engagement. The Care Management Prioritization report generates a profile for each member, highlighting key information, including their risk for various adverse health outcomes or inappropriate utilization of services (for example, diabetes, ED use); the likelihood of engagement; Care or Disease Management status; and predicted future utilization. We repeat this process biweekly for the entire membership to identify changes in severity or acuity. As members move through the continuum of severity (either up or down), we reassign them to the most appropriate level of Care Management and connect to indicated supports and services.

Targeted Predictive Analytics Tools. Beyond our risk stratification process, we drill down to identify specific member needs for more targeted interventions and outreach. **Table 52** summarizes our predictive analytic models and how our Care Managers use these tools to target and guide interventions for members across all levels of Care Management.

Table 52 Sophisticated Algorithms to Identify Members for Care Management

Predictive Analytic Tool	Utilization of Tool to Impact Care Management
Neighborhood, Economic, and Social Traits (NEST)	• Uses member and public data sources and machine learning to predict member-level risk attributed to social factors. • Once scores are aggregated by geographic region, heat maps are generated identifying the leading social indicators correlated with poor health outcomes.
Start Smart for Your Baby® Risk Model	• Our Start Smart for Your Baby Risk model identifies pregnant members with an elevated possibility of delivering a baby with high risk. This tool risk stratifies the entire pregnant population, including members that have not submitted a pregnancy risk assessment. • ***In 2021, we enhanced our model by including additional SDOH variables, which has proven to increase performance across all model diagnostics, including sensitivity, specificity, and accuracy.*** Our enhanced model has increased our positive predictive value by 20 percentage points, maximizing the efficiency of Care Management outreach.
Diabetes Predictive Model	• Identifies members for outreach and assistance who have pre-diabetic symptoms, are at risk of becoming poorly controlled, or currently have uncontrolled diabetes.
High ED Utilization	• Identifies members with potentially high ED utilization and assesses the probability of high ED use within 365 days of an initial ED visit, allowing us to proactively intervene and reduce barriers to access, such as SDOH.
Readmission Prevention	• Assigns a probability of readmission by a member at the time of acute inpatient admission to assist discharge planners and Care Managers with prioritizing post-discharge outreach. • This maximizes the efficiency of outreach by directing resources to members most in need.
Care Management Engagement Score	• Predicts how likely a member is to engage with Care Management staff who make outreach. Supports staff to work more efficiently and effectively, quickly referring members that may be difficult to engage for more intensive efforts.
Care Management Impactability	• The Care Management Impactability model predicts the likelihood that a member will be positively impacted by outreach via Care Management. • This model has a sensitivity metric of 92%, meaning it returns few false-negative results and maximizes the efficiency of outreach by directing resources to members in need.
BH Risk Model	• We developed a BH Risk model to increase the likelihood of identifying members with health risks related to BH. • Our proprietary model identifies members that may need BH Care Management, informing outreach and directing resources to members in need of BH supports.
Learn, Identify, Follow and Treat (LIFT)	• LIFT is a machine learning predictive model that identifies members before they may meet the threshold for a SUD. • While a high-risk stratification within LIFT does not confirm a SUD diagnosis, it indicates that the member may benefit from proactive outreach.
Substance Use Disorder (SUD) Segmentation	• Using evidence-based criteria and claims data, our SUD Segmentation model stratifies individuals into one of six SUD segments based on utilization, clinical severity, and cost for appropriate and timely follow-up and interventions. It provides a measurement framework to measure intervention efficacy and health improvement over time.
Opioid Risk Classification Algorithm (ORCA)	• Machine learning model that identifies which members are at high risk for having an undiagnosed opioid addiction.
Suicide Prevention	• The Suicide Prevention model predicts a member's likelihood of having a suicide-related claim within the next 30 days. Once identified, the member is flagged for outreach via our "Choose Tomorrow" clinical program. • This model has a sensitivity metric of 84%, meaning it returns few false-negative results, helping us appropriately identify suicide risk, determine the best course of the intervention, and monitor the member's treatment progress to improve outcomes and prevent suicide.
Schizophrenia Inpatient Model	• Utilizes schizophrenia-related claims data to identify members with increased risk of relapse, such as failure to fill medication prescriptions.
Social Isolation Predictive Model	• Clinically validated predictive model that uses our proprietary algorithm and member level data, including member demographics, diagnoses, and claims history, to identify members

Predictive Analytic Tool	Utilization of Tool to Impact Care Management
	at risk of loneliness and social isolation. This allows us to conduct outreach to screen the member and engage them in the appropriate program to fit their goals and needs.

Care Manager Insights. We recognize that data does not always reflect all that is happening in the member's life. Information we obtain directly from members as part of the assessment process helps Care Managers understand their specific needs, individual differences, strengths, desires, and preferences. This information can effectively facilitate member-driven, person-centered care planning and goal development. When determining risk stratification, staff consider current and historical factors, including acuity of chronic conditions, BH disorders, maternal risk, inpatient or ED utilization, SDOH, and safety risk factors.

Conducting Health Risk Assessments (HRAs) for Members Potentially Eligible for Care Management

We conduct outreach to complete the HRA to 100% of members stratified into low, moderate, or high-risk levels of Care Management. This approach to 100% outreach also extends to members of our HIDE SNP population. For our 2022 HIDE SNP product launch, 100% of our members received HRA outreach. Our proprietary, evidence-based HRA provides a complete picture of members' needs by assessing functional abilities; medical conditions; BH needs; co-morbidities; social, environmental, and cultural considerations; medications; and informal support systems. Nebraska Total Care also uses an age-appropriate assessment process to assess the BH needs proactively and retrospectively of children and adolescents. We use assessments such as our proprietary Complex Care Management Assessment to capture the holistic needs of members with special health care needs. We use this assessment to inform the member's plan of care and their multidisciplinary care team. Our proprietary, evidence-based HRA contains all elements required by MLTC and meets NCQA standards.

Engaging Members with High Cost and High-Risk Conditions in HRA Completion. Our no wrong door approach leverages every member contact to complete the HRA. We use our Care Management Prioritization Report to prioritize outreach for HRA completion for those who may most benefit from Care Management services. Engagement starts with identifying the member's needs, preferences, and goals. We match interventions and programs based on member feedback and stage of engagement. Care Managers and multidisciplinary care teams assess and address SDOH, linking members with community-based resources such as housing, employment, and social connections. To ensure we are proactively engaging youth in foster care, our Foster Care team works with the Nebraska Division of Child and Family Services (DCFS) to facilitate completion of the HRS, HRA, and other assessments with youth involved with DCFS.

Our approach to engagement is person-centered and community anchored. Similar to initial HRS engagement, we make multiple attempts to engage members using a variety of high-touch and high-tech methods, such as in-person, virtual, and telephonic outreach. We use available data on preferred language and outreach methods captured in TruCare Cloud, our care management platform, to engage members according to their preferences. Our Care Management team includes licensed staff who may conduct the HRA face-to-face in the member's home, community setting, residential care setting, or hospital. Care Management staff work with members and their caregivers and authorized representatives to schedule a convenient time and location for conducting the HRA. They may also complete the HRA over several sessions to prevent member fatigue. Our teams include CHWs who provide location services to help locate members who are reluctant to engage in care. Our CHWs meet with members in their homes or in the community to provide culturally relevant one-on-one support and connection to a Care Manager for HRA completion.

Care Management staff complete training in cultural sensitivity and unconscious bias. We use evidence-based practices, such as motivational interviewing, trauma-informed care, person-centered care planning, and the strengths-based model to engage members with high-risk who may benefit from Care Management. These staff members are embedded in the community, meeting members and families where they are and targeting information and interventions to members' willingness to engage, health literacy, degree of trauma, disparities, and cultural preferences.

Nebraska Total Care also provides education to PCPs to help them identify members with special health care needs such as high-risk pregnancies, co-morbid conditions, and complex BH needs, and then connect them back to us to complete an HRA. Trainings range from support for integrated care and evidence-based practices, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), to public health models such as Mental Health First Aid (MHFA). By engaging members with high risk at the point of care, we support the PCP relationship while enhancing care coordination for those members who are the most vulnerable.

Proposed HRA Template. Our proposed HRA template is compliant with SOW Section V.L.5.c and is included as **Attachment B.52 HRA Template.**

53. Describe the specific types of services members will receive at each risk level.Provide recommendations for additional innovative care management strategies, if any, MLTC may want to consider. ***Page Limit: 5***

Providing Services Curated for Each Risk Level

Our Care Management model promotes early identification and timely intervention, connecting individual members with appropriate services to meet their unique needs and preferences in their home or least restrictive settings. Nebraska Total Care integrates and analyzes data from multiple sources and uses industry-leading stratification and predictive modeling technologies to enroll members in the right level of Care Management at the right time.

We develop a whole-health, person-centered plan of care that promotes self-management and health literacy and leverages available community resources to provide healthy opportunities that address Social Determinants of Health (SDOH). Services at each level are designed to improve health outcomes, reduce disparities, and increase health equity. Demonstrating our commitment to health equity, ***we are actively pursuing Health Equity Accreditation through NCQA, anticipated in October 2022.*** This will give us an even greater opportunity to ensure services at every risk level is provided through a health equity lens.

Our Care Management model includes four levels of Care Management, supported by the transition of care activities and other clinical and social programs targeted to meet the unique needs of special populations, collectively referred to as *Care Management* in this proposal response. We stratify each member into one of four levels of Care Management using a combination of screenings and assessments, referrals, and predictive modeling methodologies. Using our model, we assign members to the following levels of care:

- **Healthy Engagement/Monitoring.** Focuses on members with low risk, including healthy children/adults and members experiencing acute episodes (e.g., fracture, appendectomy). Programs encourage member engagement in health promotion and preventive care, including dental care. We stratify eligible members who decline Care Management into this level and contact them at least quarterly to encourage engagement in Care Management, ***exceeding Contract requirements***. Care Management staff monitor members' service utilization to identify rising risks.
- **Low Risk/Episodic Support.** Focuses on addressing SDOH, navigation assistance, self-management of conditions, intermittent or short-term care transitions, and identifying and addressing emerging needs to prevent escalation to moderate risk (for example, health coaching).
- **Moderate Risk.** A moderate risk level of service with a program specialist or licensed Care Manager, based on member need, provides assistance with Care Coordination or accessing care to address their chronic health issues, acute care conditions, or SDOH needs.
- **High/Critical Risk.** Focuses on serving members with complex Physical Health (PH), Behavioral Health (BH), and/or SDOH that require a higher level of staff expertise, intensity, and interventions. A licensed professional Care Manager supports these members. This level aligns with NCQA Complex Care Management standards and MLTC requirements.

Expanding Services for Members at All Service Levels

Our mobile dental van, Flossy, will offer fluoride varnish in areas with dental access inequities, starting in Summer 2022, in North Platte. The fluoride will be offered to both children and adults to help close service gaps and help prevent dental caries in individuals who do not receive regular preventive care.

Our person-centered Care Management model recognizes that every member has different needs, commanding varying levels of service and interventions. For example, while every member will not require the highest level of service and intervention, any member may, at some time, need a higher level of service and support, such as short-term or intermittent coordination of services or transition of care services.

Nebraska Total Care's model addresses the individual needs of members across the entire continuum of care, recognizing that members may move between levels of Care Management at any time as their health needs and status change. It ensures that we support each member with a skilled Care Manager or Care Management staff with the specialized training needed to optimally address the member's current needs.

Services Provided to Ensure Healthy Engagement/Monitoring. We offer individualized education for members in the healthy engagement/monitoring service level to learn and improve self-management for specific conditions. Members have access to health alerts, screenings, and claims through the secure Member Portal. We provide print and electronic materials, prevention and wellness programs, outreach campaigns, and support connecting to resources that address SDOH needs. Members at this level also receive access to:

- Digital and virtual engagement tools such as the Member Mobile App
- In-person and virtual community events
- Care gap closure support

- Member incentive programs (for example, reward for completing the Notification of Pregnancy form)

We also refer members who decline participation in high-risk Care Management to this level of care for quarterly outreach and ongoing monitoring of service utilization and claims. We use this information to engage or re-engage members needing a higher level of support to maintain or improve their health and wellbeing.

The following member profile illustrates the support received in healthy engagement/monitoring.

Helping 'Lea' and 'Jim' Adjust as New Parents. Lea and her husband, Jim, were new parents to a baby girl. Following Lea's delivery, our Care Manager (CM) reached out to Lea to check on them and the baby. Lea and Jim voiced frustration that the baby was fussy and cried a lot. Using motivational interviewing, our CM learned they were feeling anxious as new parents. Our CM educated Lea and Jim on normal infant developmental crying patterns, coping methods, helped them develop a plan to manage the baby's crying, and provided additional educational resources on infant care. Lea and Jim were thankful for our CM's help and informed our CM they felt more relaxed and confident in caring for their baby.

Services Provided to Members with Low Risk. Our low-risk services include supporting and engaging members, families, and caregivers to be active participants in health screenings and health management. We provide appropriate and understandable education and support that meet the literacy needs of members and their families. We provide education, interventions, and support in multiple formats and combinations, including in-person instruction at home or in providers' offices, along with guidebooks, coaching, equipment, and websites. Our goal is to accommodate member and parent/guardian/authorized representative cultural and linguistic needs, health literacy, reading proficiency, learning styles, and changing circumstances. We provide monthly telephonic contacts or contact the member at their preferred frequency to provide ongoing support.

Members identified as low risk have access to services such as:

- Assistance with appointment scheduling and identifying participating providers, when necessary
- Assistance with Care Coordination and accessing primary care, BH, preventive, and specialty care
- Coordination of discharge planning
- Continuity of care that includes communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation
- Assistance with referrals to social supports and community resources that may improve members' health and living circumstances, including nutrition, education, housing, legal aid, employment, social support, and issues related to physical or sexual abuse; we provide staff-coordinated support and access to the user-friendly Findhelp Community Resource Platform
- Follow up with members and providers through regular mailings, newsletters, or face-to-face meetings, as appropriate

This member profile provides examples of support provided to members engaged in low-risk Care Management.

Supporting 'Juan' to Better Manage his Diabetes. Juan had been highly engaged with our Diabetic Coaching Program which helped him begin to live a healthier life through improved nutrition and exercise. While participating in the program, Juan injured his ankle, preventing him from exercising. In response, our Diabetic Coaching team helped Juan modify his meals and introduce more fruits and vegetables. With continued support through the program, Juan lost 18 pounds, lowered his A1c, and decreased his insulin needs.

Services Provided to Members with Moderate Risk. A moderate risk level serves members who need support in addressing chronic health issues, acute care conditions, or SDOH needs. Moderate Care Management involves a purposeful plan to impact members' health and health care utilization by coordinating all services and educating them about the appropriate use of those services. Care Managers at this level provide comprehensive coordination of services, including covered and non-covered services and community-based resources. The Care Manager educates members on the use of appropriate levels of services, facilitates pharmacy refills, and assists with scheduling appointments, locating specialists, and arranging transportation.

Community Health Workers (CHWs) provide in-person outreach for members that we are not able to reach by telephone or those difficult to engage (such as members with unstable housing). Care Managers will work directly with the member's PCP and other specialty providers to coordinate care through ongoing, direct interaction. We provide bi-monthly or monthly contacts, depending on member needs.

Members identified as moderate risk receive low-risk and healthy engagement services, in addition to more intense services as applicable, such as:

- Facilitate relapse prevention plans for members with depression and other high-risk BH conditions and their PCPs (including patient education, extra clinic visits, or follow-up telephone calls)
- Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence
- Facilitate group visits to encourage self-management of various PH and BH conditions/diagnoses, such as pregnancy, diabetes, or tobacco use
- Educate provider office staff about symptoms of exacerbation(s) and how to communicate with members
- Condition-specific chronic condition management and coaching
- Joint engagement with community partners
- Start Smart for Your Baby® (Start Smart), our comprehensive perinatal Care Management program
- Health coaching
- ED Diversion/Readmission Prevention programs

The following member profile is an example of the services provided to members with moderate risk.

Improving 'Beth's' Independence. Beth has multiple sclerosis and diabetes and needed a power chair and lift to be able to get out of bed. Our Care Manager (CM) coordinated with Beth's Primary Care Physician (PCP) and the durable medical equipment provider to ensure Beth had the equipment she needed. While Beth waited for her equipment, our CM arranged for an in-home PCP visit to address several care gaps related to Beth's diabetes. With the arrival of the power chair and lift, Beth's independence increased and she was able to attend her regular PCP appointments. Our CM continues to help Beth manage her health and maintain her independence.

Services Provided to Members with High or Critical Risk. Members with high or critical risk have complex, chronic, and co-morbid conditions, including members experiencing homelessness, requiring a clinical level of support. We assign members in this level of service a Care Manager (Registered Nurse or licensed BH Clinician) who serves as the member's primary contact. The Care Manager assists with navigating extensive resources and systems by actively coordinating care and services with the member and between providers. The focus is on working closely with members, their families, natural supports, PCPs, and various specialty and ancillary service providers to help members gain optimum health and improve functional capability in the right setting and cost-effectively. Members at this level receive weekly contacts until they are stable, then monthly contact at a minimum, depending on their needs and preference. This includes support necessary to prevent avoidable inpatient hospitalizations/re-hospitalizations.

Members identified as high risk will receive Care Management services included in healthy engagement, low, and moderate acuity, and more intensive services as applicable, such as:

- Organize care using a person-centered, multidisciplinary primary care and specialty treatment team to assist with the development and implementation of individual plans of care, that are per State quality and utilization management (UM) standards
- Connection to community resources to address SDOH, treatment needs, and other supports for referrals, including crisis supports such as the "741741 Crisis Text line"
- Plan for coordination and communication with State staff who are responsible for the management of home and community-based services (HCBS) waivers
- Health Assistance, Linkage, and Outreach (HALO) program addressing SUD, opioid use disorder, and inappropriate prescribing of opioids
- Develop a process to engage members who have difficulty adhering to medications or plan of care interventions
- Develop a strategy for communication with members and their families, key service and support providers, and local social and community service agencies
- Identify providers with special accommodations (for example, sedation dentistry)
- Educate staff about barriers members may experience in making and keeping appointments
- Dedicated, intensive community resource coordination and referral to ensure complex social needs are addressed, and direct enrollment in plan-provided social needs interventions
- Communicate about care gaps to ensure members obtain baseline and periodic medical evaluations from their PCP
- Facilitate provider home visits for members that are homebound
- Joint engagement with community partners, including justice, Department of Children and Family Services, HCBS

Impacting Health Outcomes

From 2017 to 2021, Nebraska Total Care's HALO SUD reduction program helped reduce opioid prescriptions per 1,000 by 51%.

waiver services providers, and other State partners
- High-Risk Maternity Care Management program through Start Smart

This member profile provides examples of services received by members with high/critical risk.

Using Clinical Judgement to Quickly Help 'Sue'. Sue is a new member with a history of liver failure and cirrhosis due to Alcohol Use Disorder. Our Care Manager (CM) reached out to Sue to help Sue manage these conditions and coordinate her care. During the initial conversation, Sue indicated she had been experiencing severe diarrhea, sleeplessness, and rapid weight loss. Using clinical judgement and a concern for possible organ failure, dehydration, and C. difficile infection, our CM advised Sue to go directly to the ED. Sue was diagnosed with a blood clot in her abdomen and admitted to the hospital. Sue was grateful our CM told her to go to the ED. Having established trust and rapport with Sue, our CM followed up with Sue upon discharge and continues to partner with Sue to address her complex conditions.

Recommendations for Innovative Care Management Strategies for MLTC Consideration

We suggest the following innovations, which apply to multiple service levels, for MLTC to consider. Selected for their focus on health equity and social justice, we recommend these innovative Care Management strategies because we believe they will significantly impact the most vulnerable members we serve. These innovations may impact MLTC policies and could be considered for implementation across MCOs to further impact member health outcomes.

Homeless Management Information System (HMIS) Integration. We serve as a partner with the State to streamline efforts to enhance healthy opportunities for members. As an example, we joined the State as a stakeholder on coordinated entry through the HMIS. This provides a centralized referral process for chronically homeless members via direct integration with the HMIS, the national housing resource database hosted by the U.S. Department of Housing and Urban Development (HUD).

Formal Certification Process for CHWs. Using our ***Neighborhood, Economic, and Social Traits (NEST) tool,*** which analyzes over 200 data points to predict the risk of adverse member health outcomes**,** and our Health Equity and SDOH KPI Dashboards, we strategically deploy CHWs in the areas of greatest need to reduce disparities and improve health outcomes.

MLTC has acknowledged that CHWs are an effective workforce in the community. To further enhance the CHW program, Nebraska Total Care suggests that MLTC consider promoting a formal certification process for CHWs. A formal certification process, already adopted in many states, will:

- Bring recognition to the profession and the work CHWs do in the community
- Recognize CHWs' diverse skills, training, and work experience, including language translation
- Increase CHW employment opportunities and potential for pay increases and stable employment
- Increase credibility

Impacting Health Outcomes

One of our affiliates was the first in the country to integrate directly with the HMIS, thus positioning Nebraska Total Care as part of a national network having a proven model. HMIS integration resulted in:

- 253% increase in wellness visits
- 131% decrease in hospital readmissions
- 69% decrease in inpatient stays
- 50% decrease in crisis services
- 21% decrease in Medicaid spend

Communication Between Unaligned Payers. States are increasingly seeking ways to better integrate care for people dually eligible for Medicare and Medicaid. They are among the highest need and highest cost populations in either program due to a high prevalence of multiple chronic conditions, PH and BH needs, and need for Long Term Services and Supports (LTSS). To promote communication between unaligned payers, Nebraska Total Care asks MLTC to consider:

- Building and maintaining a list of primary contacts at all the major MCOs in the State
- Conducting periodic meetings with other health plans to discuss members with complex needs
- Implementing contractual requirements for MCOs (D-SNPs and MLTSS plans) that share unaligned members to communicate and coordinate regularly and notify LTSS plans within 24 hours of any ED, hospital, or skilled nursing facility admissions

This enhanced Care Coordination can impact health outcomes, as information about inpatient stays, care transitions, and service needs can be shared more efficiently and effectively across payers.

Pathways HUB. The Pathways Community HUB model is an evidence-based, outcomes-payment care model based on confirmed risk mitigation. The functions of the Pathways Community HUB are to centrally track the progress of individuals to avoid duplication of services and address barriers and problems as they arise, monitor the performance of CHWs to support payments for their work, improve the health of vulnerable and underserved populations, and to evaluate the

overall performance of the organizations to support payments, promote continuous quality improvement and secure additional funding.

The HUB's pay-for-performance service delivery model improves health outcomes by developing a "pathway" to remove barriers to care, assist with SDOH, and attach individuals to primary and specialty care. Pathways are tracked to completion, and the comprehensive approach, with a high level of accountability, leads to improved outcomes and reduced costs. The HUB model enables partners to share resources, data, and administrative functions through a centralized process, whereby the HUB holds all contracts with payers and community-based organizations.

Nebraska Total Care is part of the core team working to bring a HUB entity to Douglas County, which has high rates of health disparities. Focused first on maternal and infant health, the HUB will provide support and education and use life experience to help connect members to community resources through trained CHWs. The program produces a return on investment of $2.36 for every $1.00 invested. High-risk mothers in a community HUB service area where the member was not exposed to any community hub activity were 1.55 times more likely to deliver a baby needing Special Care Nursery or NICU care when compared to high-risk members who received HUB services through delivery.

We will launch a two-year evaluation of the HUB program once the program is live. We suggest to MLTC that this program be covered as part of Medicaid benefits based on evaluation results.

Reach-In to the Justice-Involved. We will hire dedicated Justice Outreach Coordinators to provide in-person outreach (reach-in services) to the justice-involved population who reside in county detention centers and correctional facilities throughout the State. This allows pre-release planning collaboration with members and other contracted State and County entities that provide care in the facility; provides member education on resources and benefits; and facilitates screening and assessments to identify PH, BH, and SDOH needs with our Care Management team. We will also have a dedicated Justice Liaison who focuses on system engagement to support justice-to-community transitions.

Community Re-Entry Program. We recognize that there is currently no system for detention or correctional facilities to notify MCOs that a member is due for release. To address this barrier, under the leadership and direction of MLTC, we propose to work with MLTC, MCOs, and jail and prison leaders to develop systems and processes to support data sharing and coordination. We believe this could be a best practice for adoption in Nebraska facilities. Our Washington affiliate's re-entry program achieved the following:

- $17k cost savings from fewer hospitalizations, readmissions, and high engagement in outpatient care
- 97.5% of engaged members remained enrolled with their health plan
- 78.6% of engaged members attended their scheduled service appointment after release

We recommend that MLTC consider reach-in and re-entry programs for statewide adoption based on program outcomes. We will share data with the State once available.

Reducing Recidivism

When one of our affiliates implemented a jail-based high-intensity Care Management program to assist its members with reentry, it resulted in a 28% decrease in arrests and a 22% decrease in ED use over 12 months.

54. Describe how the Bidder will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover. ***Page Limit: 2***

Assisting Members to Identify and Access Community Resources

Understanding how, when, and where to access services can be challenging for members, especially those with complex Physical Health (PH), Behavioral Health (BH), and Social Determinants of Health (SDOH) needs. Nebraska Total Care helps members identify and connect to non-covered community resources using the following strategies.

Predictive Analytics. Data analysis supports the development of our social strategy by identifying patterns of SDOH needs and looking at the population level indicators contributing to high NEST scores. Analyses focus on population characteristics, transportation access, food access, housing quality, socioeconomic status, and education levels and assist in connecting social needs to PH and BH strategies.

Using Predictive Models to Connect Members to Resources

The Neighborhood, Economic, and Social Traits (NEST) predictive model identifies members at risk for adverse health outcomes due to their social, economic, and environmental conditions, as well as to "hotspot" and identify communities with high needs.

Nebraska Total Care's Findhelp Platform. Care Managers, Community Health Workers (CHWs), members, caregivers, providers, and MLTC have access to the online Findhelp Community Resource Platform. Findhelp is a searchable, vetted, and regularly updated database of current health and wellness resources, including all of Nebraska and border cities like Council Bluffs, Rapid City, Denver, and Sioux City. This valuable resource is available through our public website, so members, families, caregivers, and providers may locate resources at any time. ***Findhelp is available in numerous languages and helps Care Management staff and CHWs connect members to local programs and resources that best fit their needs, including, housing, transportation, food banks, job opportunities, BH services, and more.***

Findhelp offers bi-directional communication among users to ensure effective closed-loop service referrals and data feedback. It contains features for both member and provider access to search and refers to community-based resources. We provide closed-loop referral tracking and coordination with community-based organizations (CBOs) for members, caregivers, families, and Care Management staff. We validate data at least biannually, ensuring quality data, and increasing satisfaction with the tool as a resource to improve users' access to social, behavioral, and PH resources. We use search and referral data from Findhelp to inform our SDOH analyses. Findhelp's SDOH reporting and analytic tools give us detailed insights into resource gaps which we use to develop targeted strategies to improve health outcomes. It helps identify the prevalent needs of our membership, as shown in **Figure 54**.

SDOH Mini-Screen. In addition to SDOH questions within the HRS, we will use our new SDOH Mini-Screen to regularly identify and address members' social needs. The SDOH Mini-Screen consists of questions adapted from industry-leading [redacted]ssessments such as PRAPARE and CMS Health-Related [redacted]ocial Needs Screening. ***This innovative SDOH Mini-Screen [redacted]dentifies food, housing, utilities, safety, transportation, [redacted]mployment, and social support needs within two [redacted]minutes or less.*** A member can complete the SDOH Mini-[redacted]creen in the secure Member Portal or at our Member [redacted]onnect Station self-service tablets in select FQHCs, [redacted]MHCs, and homeless shelters. Member Service [redacted]epresentatives (MSRs) assist members in completing the [redacted]DOH Mini-Screen online. Our staff document any social [redacted]eeds identified, including the SDOH Mini-Screen, in [redacted]ruCare Cloud, our care management platform. Our staff [redacted]an address the member's social needs through multiple interventions, including deploying a CHW to assist the member, alerting the member's Care Manager or using Findhelp to locate resources. Care Managers can access this information in TruCare Cloud and connect members to resources. Nebraska Total Care works with MLTC to exchange SDOH data gathered by us and by State entities to avoid duplication and enhance our knowledge of members' needs. ***In 2021, we screened over 5,000 members for SDOH needs.***

Using CHWs. Leveraging CHWs, we develop a culturally competent workforce that is responsive to Members' needs. CHWs function as an extension of our Care Management team and provide education, advocacy, social support, referral, and linkage to community resources. We fund CHWs at local public health departments to work directly in community settings (schools, daycares, workplaces) to screen, educate, and empower them to address prevention and health care issues. These paraprofessionals provide a consistent community presence, engaging members where they are and offering a range of activities to eliminate social barriers to accessing non-covered services.

SDOH Pay-for-Performance (P4P) Program. Nebraska Total Care is establishing a P4P program to further support members in accessing community resources as part of our overall value-based contracting approach. Through the SDOH P4P program, providers will administer a two-question evaluation tool (Hunger Vital Sign) based on the US Household Food Security Scale to identify children in households at risk of food insecurity. For example, to identify homeless or under-housed members, providers will administer a two-question Housing Screener adapted from the CMS Health-Related Social Needs Screening Tool. If the provider identifies a member as food or housing insecure, they submit diagnosis codes such as Z59.0 (Homelessness) or Z59.1 (Inadequate Housing) to receive an incentive payment. Once we evaluate the program's initial results, we will consider adding the promotion of closed-loop referrals. Providers will refer members with identified needs to community-based organizations and document referrals in Findhelp. Providers notify our Care Managers when members are at risk for SDOH barriers, prompting outreach and connection to community resources and services.

SDOH P4P Program

We will offer a financial incentive to targeted Providers for evaluating members' risk for food and housing insecurity, submitting appropriate SDOH screening and ICD-10 billing Z codes with the claim.

Pathways Community HUB. The Pathways Community HUB model is an evidence-based care model that uses confirmed risk mitigation to develop a "pathway" to remove barriers to care, assist with SDOH, and attach individuals to primary and specialty care. The HUB model enables partners to share resources, data, and administrative functions through a centralized process, whereby the HUB holds all contracts with payers and CBOs. ***Nebraska Total Care is part of the core team working to bring a HUB entity to Douglas County, which has high rates of health disparities.*** We are part of the national network that helped design the HUB's maternal health pathway in other parts of the country. Focused first on maternal and infant health, the Nebraska HUB will provide support and education, using CHWs to connect members to community resources.

Project Access. Nebraska Total Care is partnering with the Health Center Association of Nebraska to increase access to whole-person care for underserved populations. Together, we will support FQHCs to recruit and retain providers; streamline processes and upgrade technology; expand operational capacity and develop workforce pipelines. This work supports provider capacity to address SDOH needs at the point of care and connect members to community resources.

Meeting Members in the Community. We provide information on accessing community resources and Findhelp via newsletters, our website, and member onboarding activities including in-person home visits. We offer information on how to access community resources at community events and resource fairs and in our everyday interactions with members and families. For example, we brought our Vision Van to the March 2022 Black Family Health and Wellness event. We provided 85 refractory screenings, 36 doctor exams, and 22 additional pairs of reading glasses. We participate in several community task forces, such as the Continuum of Care committee under the Lincoln Homeless Coalition, the Olmstead Housing Workgroup, and the Metro Area Continuum of Care for the Homeless. This helps us stay engaged with the community to increase access to community resources.

Creighton University SDOH Access Partnership. We are partnering with Creighton University to allocate funding to support improved food access, access to care, and vaccination rates of individuals living in targeted zip codes in North and South Omaha. The project evaluation will help us better understand what local referral and practice patterns lead to better outcomes and will ensure funds are making the intended impact. The project will increase access to services the Medicaid program does not cover, promoting whole-person care. The following member story illustrated how Nebraska Total Care connects members to non-Medicaid covered resources.

Connecting 'Renae' to Community Resources. Renae had been unhoused for many years and struggled with accessing community and housing resources because she had low literacy skills. Our Care Manager (CM) connected Renae with the CenterPointe Street Outreach Program and Ranae was enrolled in their housing program. Our CM helped Renae apply for Social Security Disability Income, acquire items for her new home, establish care with a primary care physician, and access additional services through Family Services of Lincoln. Ranae now remains stably housed, has access to rent and utility assistance through grant funding, and is mending personal relationships with her mother and daughter.

55. Describe the Bidder's strategy to address the unique challenges when providing care and case management for dual-eligible individuals who receive their services from both Medicare and Medicaid. ***Page Limit: 2***

Care and Case Management Experience for Dual-Eligible Individuals

Nebraska Total Care partners with the State, providers, and stakeholders to ensure seamless delivery of Medicaid and Medicare benefits and services for more than 14,000 dual-eligible members. We bring extensive experience coordinating care as a Nebraska incumbent, an MCO with our own HIDE SNP, and other Medicare products. ***Our HIDE SNP serves dual-members in 37 counties, and our expansion in 2023 will have a catchment area comprising 90% of the dual-eligible population in the State***, positioning us for statewide expansion by 2024. Our parent company, Centene Corporation, serves 290,000 dual-eligible members in Medicaid Managed Long Term Services and Supports (MLTSS) and Medicare-Medicaid programs through affiliated health plans in 15 states. Our experience gives us a unique understanding of the health care needs and challenges of dual-eligible individuals at the member, provider, and system levels.

Addressing Member Challenges. Nebraska Total Care's dual-eligible members have a higher prevalence of serious physical and behavioral health (BH) conditions, including diabetes, congestive heart failure, cardiovascular disease, Alzheimer's/dementia, and depression, with 21% having significant co-morbidities such as schizophrenia, dementia, and anxiety. The health needs of dual-eligible members over 65 differ from that of younger dual-eligible members with a higher degree of physical disability and serious mental illness. Dual eligible members rely on a fragmented health system, with Medicare paying for primary and acute care services and Medicaid paying for BH services. ***Our model maximizes the impact of resources on the population while providing the most appropriate level of services for individual members and payer sources.*** This approach ensures appropriate utilization of available Medicaid benefits and community resources to wrap around the member's Medicare-covered services and benefits. We provide medically necessary Medicaid-covered services to dual-eligible members if Medicare does not cover the service. We work with other entities, including Centers for Independent Living, Area Agencies on Aging, and community-based organizations, to link dual-eligible members to resources such as housing and utility assistance, food assistance, public transportation, caregiver support services, and other health and social support services to address the whole health needs of the individual.

Proactive Coordination and Documentation for Dual-Eligible Members

Nebraska Total Care immediately begins coordination of benefits by assessing the State 834 eligibility files for sources of coverage, whether they are aligned or unaligned, and whether their Medicare providers are enrolled with Nebraska Medicaid. We make a welcome call and complete a Health Risk Assessment (HRA), if one is not already on file with their Medicare payer, to determine the appropriate level of Care Management to address the member's unique needs. We document this information and information about other Case Managers involved in the member's care in TruCare Cloud, our care management platform. If other coverage information is included in the State 834 eligibility file, it is automatically uploaded into the Unified Member View (UMV) component of our Management Information System (MIS). UMV stores member enrollment and eligibility information and distributes to TruCare Cloud where Care Management staff are notified of member other coverage and third-party liability (TPL).

Community Partner Portal. Recognizing that the coordination of multiple entities is critical to Care Coordination, Nebraska Total Care will use the secure Community Partner Portal to bi-directionally share information. The Community Partner Portal enables the member's care team to securely access key member and provider demographic and clinical information. Users can view member eligibility status, care gaps, health record data (immunizations, allergies, and labs), other insurance information, and plans of care, and can upload key documentation including assessments and plans of care.

Coordinating Care Management

We recognize that the State's dual-eligible population receives their Medicare services through Medicare fee-for-service (FFS) and Medicare Advantage (MA) Plans. Care Managers work with Medicare payers and providers to ensure the dual-eligible member can access services included in their plan of care in a timely, appropriate, and cost-effective setting. To facilitate this process, we educate providers on dual-eligibility in Nebraska for Medicare and Medicaid, the care experience of dual-eligible members in Nebraska, and coordination of services and benefits for dual-eligible members, including billing and claim submissions. If a member is enrolled in another MA health plan, our Care Manager identifies whether they have a Care Coordination resource and works with appropriate staff to ensure consistency in care planning and access to services while avoiding duplication.

Our Care Manager works with the Case Managers of other entities to establish protocols for coordinating services, including sharing information about assessment, reassessments, plans of care, change in condition and status, transition of care, and

monitoring. For example, our Care Management and UM staff work with Medicare providers, Case Managers, and hospital discharge staff during care transitions. Together they ensure appropriate Medicaid supports and services are provided during transitions from hospital to home or community-based setting, hospital to a nursing facility, or nursing facility to home or community-based setting. Our goal is for members to maintain the highest level of wellness, safety, and independence in the least restrictive setting possible. Our Care Managers make and document attempts to involve and communicate with the Medicare provider and/or Case Manager. When there is no resource at the MA Plan level or if the member receives services through Medicare FFS, our Care Manager and Care Team lead the individual's plan of care to ensure the member receives Medicaid wraparound services.

Integrated Plan of Care and Care Management. ***We focus on the member by providing that individual, and their support system, one primary Care Manager with whom to build a relationship of mutual trust and understanding.*** Based on identified needs and risks, we assign the member to an appropriate level of Care Management. Recognizing that many dual-eligible members may be eligible for LTSS and waiver services, we identify eligibility for these benefits and coordinate with their waiver services Care Manager when applicable. The Care Manager actively engages with the member to coordinate the full range of medical, BH, functional, and social support needs, regardless of payer source. Member resources include:

- Education of members on the breadth of their Medicare and Medicaid benefits
- Assistance in coordinating the Medicare and Medicaid services that are available to the member
- Dedicated helpline for HIDE SNP members to answer questions about coverage

Recognizing that members' social needs are constantly changing, we screen members for Social Determinants of Health (SDOH) needs at every member contact and collect SDOH data from various sources. We use our ***Neighborhood, Economic, and Social Traits (NEST)*** tool to predict member-level risk attributed to social factors. Informed by this information, we proactively outreach to members to connect them to resources and engage them in services.

The Care Manager works with each dual-eligible member and their support team to develop a written person-centered plan of care, addressing the member's SDOH needs, preferences, and supports required to stabilize or improve the member's health and well-being. The plan of care serves as a single source for planning and facilitates increased communication with the member, providers, and the member's family, community, and social supports.

We document assessment results and plans of care in TruCare Cloud, which creates a shared record and provides evidence of collaborative Care Coordination. The member's plan of care may include Medicaid-funded BH or Medicare-funded physician or hospital services. We coordinate with internal and external HIDE SNP Care Management, out-of-network, and community providers, including Medicare providers, to ensure care integration and avoid duplication in the member's plan of services and support. We train our Care Management staff about Medicare and Medicaid benefits, including those covered by both, such as Durable Medical Equipment and home health. ***Nebraska Total Care meets the unique needs of each member by focusing our Care Management approach on the dual-eligible individual, regardless of the primary payer for a particular service.***

Helping 'Larry' Access Stable Housing. Larry had been paralyzed due to a gunshot wound, had a history of depression and chronic, non-healing wounds. Larry required assistance with activities of daily living, including help transferring from his bed to wheelchair. Larry was recently admitted to the hospital for sepsis. Upon clinical review, our Utilization Management team referred Larry to our Care Management (CM) team to help coordinate his discharge and, Social Determinant of Health needs, and ongoing care. As a previous victim of violence, Larry was afraid for his safety and did not want to leave the hospital. However, our CM team established trust and rapport with Larry and partnered wit h our Community Disabilities Coordinator to establish a safe discharge plan and help Larry transition to supportive housing where he now continues to live independently.

56. Describe the Bidder's strategy to address the unique challenges when providing care and case management to members who are chronically homeless or are at risk for homelessness. ***Page Limit: 2***

Care Management for Members Experiencing Housing Instability

Nebraska Total Care serves 900 members experiencing homelessness with the highest populations located in Douglas, Lancaster, and Hall Counties. Our innovative Housing and Health Continuum framework (**Figure 56.A**), the ***Thrive Model,*** follows a housing-first approach and includes a broad base of engagement strategies, community partnerships, Social Determinants of Health (SDOH) programming, and strategic investments. This framework meets members where they are, helps them work toward stability, and achieve continuing self-sufficiency by addressing both urgent and long-term needs. Our Thrive Model includes three primary pillars, Coordinate, Bridge, and Thrive, to link members to appropriate health, social, and housing services. Informed by this framework, we use a multi-pronged approach to identify and engage with members across Nebraska's Continuum of Care (CoC) and partner with communities to provide wraparound support.

Figure 56.A Nebraska Total Care's Thrive Model

Continuum	Coordinate Homelessness Support Services	Bridge Transitional Housing	Thrive Permanent Supportive Living
Initiative	• Coordinated Entry Program Statewide • myLNK App • Identify Eligible Program • FindHelp • Emergent SDOH needs • Referral to CHW • Eviction Prevention • ConnectionsPlus® Phones	• Bridge Housing Placement • Housing and Health Wrap-around Services • Coordination of Permanent Supportive Housing options • Rapid Housing	• Independent Living Skills • Tenancy Support Services and Financial Literacy Counseling • Required Home Modifications
Social/ Health Impact	• ED visits, IP and RX utilization • Services Utilized • Perceived Stress • Homeless Days Reduced • Functional Living Status	• ED visits, IP and RX Utilization • Services Utilized • Homeless Days Reduced • Member/CBO satisfaction	• Housing Placement • Quality of Life • ED, IP, and RX utilization • Homeless Days Reduced • Member/CBO satisfaction
Community Partners *indicates SUD treatment providers	• 211 and CBOs • Family Housing Advisory Services • Regional CoC Systems • Homeless Coalitions • DHHS • Project Homeless Connect • The HUB • CenterPointe* • Community Action Partnerships • Family Service Lincoln • CEDARS • People's City Mission • Together • Siena Francis House* • Cirrus House	• Oxford House* • Salvation Army* • Heartland Family Services* • Youth Emergency Services • Stephen's Center • CEDARS Bridges • The Able House • Jacob's Place • Santa Monica* • The Bridge • Houses of Hope* • Central Nebraska Community Services	• Sienna Francis House* • Heartland Family Services • Behavioral Health Regions • Community Alliance • Open Door Mission • Local Housing Authorities • HUD • Public Housing Authority • Fostering Stable Housing Opportunities Section 8 Vouchers • Connected Youth Initiative • Project Everlast

Coordinating Homeless Support Services. Our person-centered approach extends beyond traditional health care systems and targets places where members find safety and shelter. Our Program Coordinators use a variety of tools –predictive modeling, homeless indicator information from the 834 eligibility file, foster care status, Nebraska's Coordinated Entry System (CES), and other data analytics – to identify members with no address, frequently changing addresses, or a shelter address, and follow these leads to physically find and engage them. Aging out of Foster Care is a major driver of youth

homelessness. About 30% experience homelessness within two years of exit, with an even higher rate for Black youth. Our team places a special focus on identifying former foster youth through telephonic, virtual, and in-person outreach. Recognizing that members who are experiencing homelessness have limited resources and experiences that include trauma, Care Management staff use evidence-based practices such as Motivational Interviewing, Trauma-Informed Care, Person-Centered Care Planning, and the Strengths-Based Model. Our staff is embedded in the community, aligning information and interventions to a member's engagement level, health literacy, degree of trauma, and cultural preferences. We approach each member as unique, guiding self-identified needs and goals and member-driven action steps. We help members engage with the CES for housing, and apply for eligible programs such as WIC, food stamps, and SSI. We help youth in foster care opt into Nebraska's Bridge to Independence program and assist foster care alumni in applying for Fostering Stable Housing Opportunities Section 8 Vouchers.

Building Bridges to Housing. Our dedicated Housing Team, consisting of social workers, CHWs, and our Community and Disability Liaison, focuses on housing stability and addressing underlying issues such as substance use and SMI that contribute to chronic homelessness. We partner with a broad network of shelters and agencies supporting members experiencing housing instability throughout the State, including housing continuums of care such as the Metro Area Continuum of Care Homelessness and the Lincoln Homeless Coalition. We build bridges to housing such as temporary hotel stays, short-term rental assistance, transitional housing (including recuperative care), and long-term housing.

Rapid Response. Based on the success of our affiliates, we are piloting a Rapid Response program for members experiencing homelessness who present at EDs. We will partner with CHI Health Creighton University Medical Center University Campus and Bergan Mercy Campus to pilot our Rapid Response program at their EDs within our Health Equity Zones to receive real-time notification of admission so Care Managers can connect with members. We will offer on-site support, in coordination with ED social workers, to connect members to a medical home, and ensure discharge to a safe place. We will offer hygiene care kits, which include items such as socks, toothbrushes, toothpaste, and pre-programmed cell phones to increase connection.

Community Health Workers (CHWs). Our locally-based CHWs complete a 50-hour Member Connections Community Health Training. CHWs provide member education, care gap closure, and address members' SDOH. For members who are particularly difficult to engage, we partner with ***Best Foot Forward***. Their outreach includes location services, assistance with HRS completion, Notification of Pregnancy Form submission, and benefit education. ***Best Foot Forward has a 58% success rate in engaging members who are difficult to reach and helping them with completing the HRS.***

Homeless Team Impact

January – April 2022 our homeless team received 156 referrals and facilitated the following member outcomes:

- 114 linked to community housing
- 15 approved for housing assistance and moved into new housing

Our dedicated homeless team provides closed-loop connections to resources via the Findhelp Community Resource Platform. With staff embedded in the community, we continually update our in-depth resource list which includes peer support programs and providers skilled in working with people who experience homelessness. As part of our Housing First Model, we are in discussion with the State to enable strategic data sharing with Nebraska's Homeless Management Information System (HMIS). This will allow us to proactively identify members who are homeless or housing insecure, and help them move to self-sufficiency. An affiliate health plan used this approach with their state's HMIS; ***after six months, the number of members experiencing homelessness decreased by 24%.***

Helping Members Thrive in their Communities. We leverage partnerships to link members to services that help them thrive and move toward self-sufficiency, at their own pace, including medical services, substance use treatment, BH care, Medication-Assisted Treatment, food and clothing, and job training. Our staff present wellness seminars in community venues to teach self-care skills. We partner with EmployOMA, a collaboration between Nebraska Vocational Rehabilitation and Nebraska Easter Seals, to connect people to stable employment through job fairs, job readiness classes, and employment opportunities. To further assist with employability, we provide GED attainment support.

Helping Members Overcome Unique Challenges. Sally is a member with diabetes, hip arthritis, hypothyroidism, and lymphedema. She called her Care Manager, Allie, as she was not feeling well and in need of diabetic supplies. Allie ascertained that Sally was living in her disabled car and there was an impending snowstorm approaching. Allie used Findhelp to locate Community Action Partnership (CAP) and placed a three-way call seeking assistance for immediate shelter. CAP approved funding for lodging at a local motel for a week. Allie then placed multiple calls to find a local motel that would accept over-the-phone payments. Thanks to CAP and a cooperative local motel, a dangerous situation was averted. Sally was able to care for herself in a warm, safe environment. Subsequently, Care Management worked with Sally to develop a long-term housing plan.

57. Describe the process for care and case management for foster children and adolescents aging out of the foster care system. ***Page Limit: 2***

Experience and Dedication to Members Impacted by Foster Care

As an incumbent, Nebraska Total Care provides trauma-informed care for over 3,000 members in Foster Care, adopted, or aging out, while incorporating more than 12 years of experience from our parent organization and affiliates, ***managing Medicaid services for over 230,000 children and youth served by the child welfare system across 19 States.***

Our deep knowledge of serving children and those who care for them, along with our community and State agency partnerships, is crucial to improving access and outcomes for youth. Children/youth in Foster Care, adopted, or aging out of Foster Care often have intensive and complex health care needs and higher Adverse Childhood Experiences (ACEs). This leads to greater Behavioral Health (BH) needs requiring more psychosocial services and psychotropic medications than other children. We leverage our systems, processes, and partnerships to facilitate coordinated Care and Case Management.

Dedicated Foster Care Team. Our Foster Care team includes licensed clinical staff, a Program Specialist, and Foster Care Liaison to directly support the member, caregivers, including adoptive, foster parents, relative caregivers, natural parents (as allowed), and the child/youth's DCFS caseworker. ***Our team has extensive training and a combined 55 years of experience in the Foster Care System, giving us a unique understanding of our State's needs and challenges and deep connections to DCFS, providers, and community resources.*** Some of our staff have experience as foster parents themselves. We work to identify and close care gaps, remove barriers, securely share information with allowable partners, advocate for services, and facilitate linkages between health care and community-based service systems. Activities include:

- *Comprehensive identification of needs* and areas for support at entry into the health plan for all foster care members, before aging out of Foster Care and ongoing through the Care Management process.
- Development of *member-centric, trauma-informed, strengths-based care plans* with the member (if age-appropriate), caregiver, DCFS caseworker, and Primary Care Provider (PCP) that includes all needed services, including EPSDT services, chronic condition services, natural and community supports, BH services, and follow-up care.
- *Ensuring every member has a PCP*.
- *Transition support* and continuity of care through changes in levels of care (i.e., hospital to home, outpatient to residential and back) and placement changes.
- *Participate as a team in State staffing* or other requested system of care meetings which allows us to provide feedback and support from each of our perspectives and ensure coordination of care.
- Support caseworkers, caregivers, and young adults in *meeting identified Social Determinants of Health (SDOH) needs.*

Whole-Person Health. Recognizing the importance of whole-person health, we meet needs outside of Medicaid-covered benefits through leveraging both external community and social service programs through the Findhelp Community Resource Platform and internal supports through Care Grant funds. Care Grant funds can pay for services or supplies not covered by Medicaid that improve members' wellbeing through social, physical, or educational activities. Examples include art supplies, mental or physical health care equipment, sports equipment, uniforms or fees to take part in self-confidence building and/or physical activities, safety equipment, and educational activities. We offer personal kits, based on members' age and needs, for children in or aging out of Foster Care to take with them as they transition to a new home to provide a sense of familiarity and continuity. Kits are available in drawstring bags or backpacks and can include hygiene items, stuffed animals, books, and personal care items.

Supporting Foster and Adoptive Parents. Beyond the empathetic support of care and case management, we offer no-cost training resources for families and system partners. Topics are designed to build skills and offer tools for children impacted by trauma, including Trauma-Informed Care, Secondary Traumatic Stress, Supporting Birth Parents, and Suicide Prevention. Our parent company, Centene, has national partnerships that inform our local approach. We collaborated with the National Foster Parent Association (NFPA) to develop online training for caregivers available via the NFPA Training Institute at no cost to caregivers nationwide, regardless of insurer. Through the Association, we offer caregivers Training on Trauma and Attachment in Children (ATTACh), with no-cost access to weekly online peer-lead support groups for youth with trauma and attachment issues. We are developing training and publications with the Child Welfare League of America that address racial injustice and the disproportionate representation of children and families of color in the Child Welfare System.

Improving Outcomes Through Innovation and Partnership. Nebraska Total Care leverages community partnerships and best practices developed by affiliates in other states to continually improve Care and Case Management for members in Foster Care, including:

Development of Child Welfare Dashboard. Our recently developed Child Welfare Dashboard is designed to inform the Care Management program by providing visibility into our membership by race/ethnicity, age, gender, and segmenting by population type within Child Welfare. Users gain a deeper understanding of access to services through various utilization metrics such as ED, primary

care, and inpatient admissions and readmissions. To understand what is being treated in these services, users can explore Major Practice Groups and Episode Treatment Groups to uncover specific health needs in the population. Additional functionality in progress includes health equity analysis, SDOH, and Care Management/Care Coordination engagement. This allows us to identify areas of opportunity for focused interventions and utilization trends.

Foster Care Center of Excellence. In 2020, we began a partnership with Children's Hospital and Medical Center (CHMC) to create a Foster Care Center of Excellence to facilitate access to primary care, dental, and BH services for children in Foster Care. In a single visit, CHMC's Foster Care Clinic provides physical examinations, psychosocial assessments, developmental screenings, dental assessments, visual evaluations, and nutritional evaluations. We developed a communications pathway between the clinic and our team that allows for discussion and collaboration on members identified as needing Care Management. ***Following the six-month pilot period, our analysis shows that members being referred to this clinic have 50% lower ED utilization compared to other providers.***

"I am very excited about this new opportunity to ensure our most at-risk children receive comprehensive medical and mental health care. I am thrilled that Nebraska Total Care has stepped forward and made this population a priority."
- Dr. Suzanne Haney, Division Chief of Child Abuse Pediatrics, Children Hospital Foster Care Clinic Director

adolescence to Adulthood (a2A) Program. Nebraska Total Care implemented the a2A Program in early 2022 based on feedback from stakeholders and affiliates' success in Florida, Illinois, Texas, and Washington. For example, our Illinois affiliate's a2A program resulted in ***41% referred to housing or independent living programs, 58% referred for employment assistance, and 48% referred to continuing education assistance*** (GED, Trade School, or college). The program focuses on supporting youth to achieve their best health and exit into the community by accessing needed services and community supports focused on their physical, behavioral, and SDOH needs. We begin outreach to youth six months before their 19th birthday to educate and empower them about a2A benefits. Youth discuss their strengths and goals to develop a Healthy Living Plan with a Care Manager. Using a customized a2A screening tool, we assess needs such as social resources/supports, depression, substance use, housing, safety, sexual orientation/gender identity, sexual health, education, and employment. ***a2A*** provides tools and resources to equip youth for safe and appropriate transitions such as: Digital Health Connect mobile platform displays health care reminders and enables digital chats with Care Managers; No-cost cell phone; YMCA membership; 24-hour Nurse Advice Line; My Health Pays program allows members to earn financial rewards for completing preventive care visits that can be used on needed items such as food, clothing, transportation, utilities, education, and rent; one-time payment up to $500 per youth to support moving to a new home

Leading Innovation and Best Practices

Education and Workforce Development. We offer members the opportunity to receive educational vouchers to support preparation for a diploma or higher education opportunities. This includes reimbursement for the fees associated with the following activities: GED test; SAT and ACT tests; and College Applications (for those who do not already qualify for application fee waivers). Nebraska Total Care is exploring opportunities to partner with local organizations to ensure members in Foster Care have a successful transition to employment, including financial literacy, job linkage and training programs, and navigating post-secondary education.

Providing Comprehensive Care and Services for 'Brody's' Complex Needs. Brody experienced a traumatic injury in early childhood which impacted his basic functioning. Brody was being cared for by a skilled foster parent and required ongoing involvement with multiple systems and specialty providers, indicating a need for highly coordinated Care Management. Brody required specialized surgeries that required long travel and a three-month recovery. Our Foster Care Liaison (FCL) coordinated service authorizations, contracts, and Brody's medical transportation. Our FCL also arranged travel and lodging for Brody's foster mother so she could be with him during his hospitalizations. When Brody was ready to return home, our FCL facilitated Brody's discharge planning, and ensured he had all needed care and services at home, therefore supporting Brody's continued health and placement permanency.

58. Describe the process for care and case management for members residing in an ALF or LTC facility.
Page Limit: 2

Supporting Members Residing in Assisted Living Facilities (ALFs) or Long Term Care (LTC)

Our Care Coordination team works with members to identify the right care, at the right time, and in the right setting, including ALFs or LTC. We accomplish this by treating the whole person, integrating Physical Health (PH), Behavioral Health (BH), Long Term Services and Supports, and other services to create a system of care around each individual. We coordinate all covered, non-covered, and community-based services to support members in their homes for as long as they desire and can be cared for safely. We receive Admission, Discharge, and Transfer (ADT) data through the health information exchange (HIE), CyncHealth, to quickly identify members who have inpatient admissions. Nebraska Total Care uses the Health Risk Screen, functional needs assessment, and supplemental transition tools (including Centelligence predictive analytics scoring) to evaluate the needs of those interested in transition. We use open-ended questions (such as where do you want to live?) to encourage thinking about community living. Care Managers develop Care Plans in conjunction with the member and/or member representative using person-centered interviewing techniques. The plan includes mutually identified challenges, goals, and interventions to support the member in reaching identified goals, which may include the facilitation of informal services and support through community providers such as CILs, AAAs, and other entities to aid in the transition between levels of care. We share Care Plans with the member's identified PCP for further collaboration and coordination.

Ensuring Successful Transitions for 'Alan'. Alan had been residing in nursing facility for several years, however, the facility was closing. Our Care Manager (CM) researched alternative living options, including independent living because this aligned with Alan's goals. Our CM located an apartment for Alan, arranged needed durable medical equipment, and secured home care services for medication assistance and to change Alan's catheter. Our CM also helped Alan establish care with a primary care physician (PCP). During his initial visit, the PCP discovered Alan had a wound and other clinical issues requiring hospitalization. When Alan was ready for discharge, his clinical needs required 24-hour care. Our CM participated in numerous meetings with MLTC, Waiver Services, APS, and the hospital Social Worker to successfully transition Alan to a skilled nursing facility capable of meeting his care needs.

Supporting Members in ALFs or LTCs. Our Care Management Team serves as dedicated contact points for ALF or LTC facilities to facilitate interaction between members, caregivers, and medical/care teams. Activities include:

- Educating facility staff on the supports we provide
- Identifying, securing, and potentially covering the cost of durable medical equipment or other wraparound services, such as lab work and home care, if needed
- Monitoring service utilization and capturing the quality of life assessment indicators, which are self-reported by members as part of the annual assessment/reassessment process
- Providing age and developmentally appropriate education for members and their families/guardians to ensure they are fully informed about available community-based options, including supportive housing
- Educating members on dental hygiene through a partnership with the National Association of Local Health Directors
- Conducting in-reach activities to identify and engage potential recipients receiving care in a facility setting who may have their needs safely met in a community setting

Combatting Social Isolation and Loneliness. ***Social isolation is worse for health than obesity, equivalent to smoking 15 cigarettes daily, and increases the risk for re-hospitalization.*** To combat this, Nebraska Total Care is implementing The Friendly Voices program, which matches community-based volunteers to members in ALF or LTC who want more social contact. The program facilitates meaningful, multi-generational connections.

Preventing Falls. Falls pose a risk for injury or death and often result in avoidable hospitalization. We are implementing nationally recognized fall prevention programs, such as A Matter of Balance and STEADI (Stopping Elderly Accidents, Deaths & Injuries) Older Adult Fall Prevention Programs. In Ohio and Texas, our affiliates apply for these programs across NF and community settings. Members learn to view falls as controllable, set realistic goals to increase exercise, strength, and balance, authorize using Personal Emergency Response Systems, and modify their environment to reduce risk factors.

Assessing Members for Transition to Community Living. With the availability of Minimum Data Set (MDS) data, our Centelligence predictive analytic tools can identify members in facilities who may be prepared to transition. We analyze member data and MDS assessments for factors that predict readiness, such as age, length of stay, and health conditions. Transition Specialists educate members and NFs about available supports. We learn of members who need assistance transitioning from hospital to community from both MLTC and UM staff during BH and PH rounds. We regularly have

meetings with provider groups to discuss complex discharges with which we can assist.

Facilitating Member Transitions to Community Living. When a member is ready to transition to a new setting, our Transitions of Care team can assist with arranging for services and support to successfully transition them from an institutional or inpatient setting back to the Member's home or community setting. This may include an assessment and authorization for private duty nursing services, medically tailored meals, and conducting environmental and home safety assessments. We recognize issues may arise after hours. In response, our Nurse Advice Line is available 24/7/365. Care Managers follow up with members through various outreach modes immediately after transition, and as needed, to monitor readmission risks and identify and address issues. Our Community and Disability Liaison and new System of Care (SOC) Liaison are resources for members and care teams to identify support systems, including Medicaid Waivers, as possible options. They educate members and providers on how to apply for benefits and help initiate that process. This allows members to have more benefit coverage opportunities for the services identified.

Supporting Facilities. Nebraska Total Care offers a clinical provider training program, focused on the ALF and LTC populations, and understanding and managing behaviors. We developed this training series in response to an identified need to assist members who were experiencing high rates of inpatient hospitalization and ED utilization due to behavior difficulties in NFs. The training focuses on the difference between behavioral management/behavioral needs and psychiatric symptoms while providing de-escalation skills. Behavior Management is a short-term intervention to safely address problematic and/or disruptive behaviors, and encourage the occurrence of positive behaviors. The training is a three-course series including Behavior Management 101, Behavior Management 102, and Behavior Management **Strategies**. ***Affiliate outcomes demonstrate an average pre- to post-test knowledge increase of 152%.*** By increasing provider skills and resources for dealing with problematic behaviors, we improve placement stability and both provider and member satisfaction. Nebraska Total Care offers provider training on our Service Coordination framework and topics that support person-centered care, including Diversity, Equity, and Inclusion; Trauma-Informed Care; Motivational Interviewing; Positive Behavioral Support; and Disease Management. For example, we offered a Lunch and Learn on Working with the Non-Adherent Diabetes Patient with strategies to improve member adherence through self-management tools, motivation, the provider-member relationship, and community resources.

Partnering for Improvement. We are enhancing relationships with partners through a new SOC Liaison to serve as a single point of contact to resolve system issues, improve cross-systems protocols, and increase coordination. The Liaison will support providers, identify and close system of care gaps and barriers, share information, and facilitate advocacy and linkages between health care and community-based service systems, including LTSS Waiver Case Management, AAAs, CILs, and IDD communities. We will build on existing relationships through current partnerships, such as the League of Human Dignity, and lead efforts to invite new providers and community organizations to the table to discuss successes, innovations, and challenges in care coordination.

Transitions. For members who have been in acute care or other inpatient settings for PH or BH needs, we use our Centelligence predictive modeling tools to develop safe and appropriate discharge plans. This evaluation offers providers a 360-degree view of the member's health care utilization, including prior admissions and readmissions (potentially failed prior discharge plans). If a member can no longer be cared for safely in their home, our Care Management team is available to meet with the discharging facility's medical team to identify placement options, including ALFs or LTC settings that meet the member's care needs. We coordinate with our Utilization Management team and consider factors such as Social Determinants of Health, support systems, and other resources to facilitate a smooth transition. We work with the nursing facility (NF) to facilitate the timely submission of a request for a Pre-Admission Screening Resident Review and level of care determination for the member, which may take up to 60 calendar days to complete. Our Transition Coordinator ensures the transfer of medical records and Care Managers support members and families throughout the transition. For members with BH issues, we work with the facility's care team (with permission) to formulate a plan that helps the member and providers manage behaviors, as members may struggle while experiencing a change in their environment.

Facilitating Transitions During Crises. With multiple NF and ALF closures statewide, our Care Managers have helped locate new placements and transition 170 members from 19 facilities since 2020. Due to the facility shortage, our team contacts facilities throughout Nebraska and in bordering states. We use all available resources to overcome challenges, find appropriate care for members, and ensure the best possible transitions, including waiver applications and transportation.

59. Describe the process for care and case management for members who are Tribal members or are otherwise eligible for care through Indian Health Services. ***Page Limit: 1***

Care and Case Management for Tribal Members

Our person-centered Care and Case Management approach respects Tribal sovereignty and prioritizes collaboration with Indian Health Services (IHS) and other Tribal health care providers. Tribal populations experience significant health disparities and barriers to care. Tribal members are 2.1 times more likely to be diagnosed with diabetes, 2.2 times more likely to be diagnosed with myocardial infarction, and 4.6 times more likely to die from homicide than Whites. Tribal members have greater Social Determinants of Health (SDOH) needs —17.5% are unemployed and 40.5% live in poverty; less access to health care—almost 25% report being unable to see a physician due to cost (11% for Whites), and 30% do not have a personal physician (17% for Whites).[2] We have developed trusting, foundational relationships with Nebraska's Tribal and Native American communities to address these disparities and improve health care services.

Dedicated Liaison. Our dedicated Tribal Liaison has bi-weekly meetings with Tribal 638 health providers, Indian Health Services (IHS), area agency leadership, Urban Indian Health providers, and community leaders, such as Tribal elders. This communication increases awareness, offers a consistent, single point of contact, and helps us stay current on issues and concerns. We meet regularly with the four recognized tribes in Nebraska (Winnebago Tribe, Omaha Tribe, Ponca Tribe, and Santee Sioux Nation) along with IHS to understand their specific priorities and build upon the strengths and resources within each Native community. Our Liaison facilitates our Tribal Health Advisory Committee, which meets quarterly and reports through our QAPI structure, informing Care Management and Community Engagement team follow-up on issues and concerns.

"I just wanted to thank you and Nebraska Total Care for all that has been done for Carl T. Curtis Health Ed Center since the pandemic started. Our patients and providers appreciate the thermometers, sanitizers, and supplies. The communication that you, as our Tribal Liaison, have provided is one that we will forever appreciate."

- Crystal Appleton, Business Office Manager, Omaha Tribe

Care and Case Management Process for Tribal Members

In tandem with IHS, Tribal 638, and Urban Indian (I/T/U); Community-based Organizations; and Tribal partners, we use all available Care Coordination resources. We leverage tools such as our Centelligence reporting and analytics platform, the Findhelp Community Resource Platform, and our TruCare Cloud care management platform. Our Care Managers work with Tribal Clinic Care Managers to share information and resources, via the Community Partner Portal to support their decision-making and program operations. We ensure access to physical, behavioral, and dental health services for Tribal members, regardless of provider type or location. We coordinate all covered and non-covered services, inform AI members of their right to receive services from both contracted and non-contracted I/T/U providers, offer unrestricted access (regardless of contract status), and seek contracts with all I/T/U providers for continuity of care.

Coordinating with Tribes

We met with the Ponca Tribe to develop Care Management community support worker processes and community diabetic Care Management. We integrated feedback into our processes, provided tailored resources, and began Diabetic counseling sessions for members with high risk factors – ***resulting in a 34% increase in tribal services and Care Management.***

Community Health Workers (CHWs). We have a team of trained CHWs to support Tribal and Native American needs as they arise. Our CHWs have completed a 50-hour Member Connections Community Health Training, receive Tribal sovereignty training, and are culturally adept and locally based across Nebraska. CHWs visit members in their homes, providing outreach, education, referrals, and Care Coordination.

Cultural Competence. We developed ***Guidelines for Working with Native American Populations*** training in partnership with the Tribal Health Advisory Committee (THAC). THAC supplied valuable cultural background, historical trauma insight, and oversight of training development and implementation. All staff and Subcontractors complete this training, and we offer live training to our network quarterly. The Ponca Tribe of Nebraska asks all new Tribe providers and staff to attend.

[2] https://dhhs.ne.gov/Reports/Health%20Disparities%20Report%202020.pdf

60. Describe how the Bidder will coordinate service planning, service delivery, and post-discharge care among discharge planners (including State psychiatric hospitals) and home health and other service providers.
• Include the Bidder's approach to care management for youth discharged from residential care.
• Explain how the Bidder will monitor the post-discharge care of members who receive services in remote areas.
Page Limit: 6

Managing Transitions Between Care Settings

Nebraska Total Care uses a person-centered, evidence-based Transition of Care (TOC) model (**Figure 60**) to facilitate holistic access to health and recovery services to ensure safe transitions to the most integrated community setting possible. We proactively identify hospitalized members before discharge, coordinate services, and connect members to the post-discharge care they need to prevent readmissions. Our approach considers needs related to barriers and Social Determinants of Health (SDOH) as important as clinical needs. We provide intensive support after discharge for those at high risk for readmission. Our TOC program is aligned with our Care Management and Utilization Management (UM) activities, including approved policies and procedures, staff training, and compliance reporting to ensure all timelines are met, members are appropriately assessed, and all barriers are addressed.

Figure 60 Transition of Care Model

Transition of Care Principles. Our TOC model emphasizes ***prevention, continuity of care, coordination, and integration of Physical Health (PH) and Behavioral Health (BH)*** for all members transitioning from one setting to another. We incorporate principles established by Dr. Eric Coleman, shown to reduce avoidable readmissions. These best practices include onsite clinical resources, member and provider engagement and education, coordination of care and services, and promotion of self-management skills. Fundamental components of our TOC model, including care transitions and Emergency Department (ED) diversion activities, include:

- Collaboration with member and facility discharge staff for transition planning to develop and implement a written discharge plan that assesses member and family needs, considers member goals, medical, dental, vision, functional, behavioral, and SDOH needs
- Caregiver engagement, assessment, and support that includes our caregiver support program with accessible information and tools specifically designed for member's informal caregivers
- Education and training for members and caregivers on the member's condition, symptom management, medication adherence, and other triggers
- Obtaining referrals, locating providers, scheduling follow-up appointments; arranging transportation, DME, supplies, and medications; linkage to non-covered services and community services to keep members safe in the community
- Linking member to PCP if needed; transferring member records to assist with coordination of care in compliance with HIPAA privacy and security rules and facilitating clinical hand-offs
- Timely communication with PCP about discharge plans and changes to plans of care
- Documentation of TOC and other Care Management activities in our care management platform, TruCare Cloud, and access to member clinical information made available to authorized users via our secure web portals
- Medication reconciliation and non-adherence monitoring by a Pharmacist
- Ensuring ADT data is available to PCP and BH providers
- Post-discharge follow-up and monitoring to ensure services are in place to effectively maintain the member safely in the least restrictive setting, with special focus on co-morbidities and complex conditions and coordination of services for high utilizers to identify gaps and evaluate the progress of Care Management
- Assistance with the transition for children being placed in foster care, including the timely assessment of children and youth as they transition to new placements or age out of the Foster Care System
- Coordination between the children and adolescent service delivery system as members transition to the adult mental health system
- Coordination with nursing facility staff for members that are transitioning into long term care to ensure timely submission of the request for a PASRR
- Coordination with the Psychiatric Residential Treatment Facility (PRTF) for when members are admitted to PRTF and

upon discharge to connect to outpatient services and community-based programs

Communication with Hospital Inpatient Providers. We establish systems that support timely notification of inpatient admissions and communication protocols that support bi-directional sharing of information and coordination between the health plan and hospital. Upon admission, we begin discharge planning and coordination with hospital discharge planning staff and inpatient providers. Our TOC team utilizes Admission, Discharge, and Transfer (ADT) feeds from hospitals and CyncHealth our daily census report to identify members with inpatient admissions. Upon identification or notification from the hospital, our TOC staff contacts the designated hospital discharge planners and our Care Management team to begin discharge planning to support safe transitions of care. Members identified at medium or high-risk care management levels (further described below) are assigned to a Care Manager if they do not already have one. The Care Management team coordinates with the TOC team, serving as the member's advocate and engaging with the clinical team to share the member's needs and preferences. Our UM staff provides concurrent review and authorization of services such as durable medical equipment (DME), home health, and private duty nursing. We meet regularly with our hospital partners to review complex cases, discuss opportunities for process improvements, and improve Care Management coordination to prevent future readmissions.

Discharge Planning for BH or Substance Use Admissions

For members who have had an inpatient BH or substance use admission, a Care Management team member communicates with the hospital or BH facility to identify the social worker or point of contact to coordinate discharge plans and ensure a successful transition. We connect with the member in the way they prefer, including in person.

Dedicated BH Hospital Discharge Planning. We have dedicated BH clinicians to support rapid discharge planning and help obtain accurate information for case management follow-up for our members. We utilize a daily census of inpatient members and address needs identified by discharge planners. Before discharge, our TOC team ensures that members have outpatient appointments scheduled within seven days of discharge. We use the post-discharge TOC assessment to manage all readmission risks, medication compliance, and other needs. All notifications and authorizations regarding hospital admissions are entered into our care management platform, TruCare Cloud. Nebraska Total Care generates daily inpatient census reports to manage utilization reviews with this information. As discharge nears, the TOC Coordinator specifically inquires about discharge plans to determine the member's BH and PH status and readiness for discharge; the patient's response to treatment; treatment needs following the level of care; the patient's interest in, and willingness to comply with, additional treatment; and challenges the treatment team may be expressing regarding locating the appropriate next level of care or community resources.

To assess for placement, our TOC team works with the facility treatment team and consults with our BH Medical Director to determine post-discharge placement needs. We review the member's age, BH and medical needs, cultural considerations, cognitive status, and SDOH needs, working with the facility to discuss member placement prioritization. We enhance ongoing Care Management with technology to meet members where they are. All BH discharges are referred to Care Management for follow-up outreach. ***In the first quarter of 2022, Care Managers conducted Post Hospitalization Outreach with 89.3% of members with a BH admission - a 10% increase yearly.***

Connecting to Care Throughout Nebraska. Kim, one of our Care Management Social Workers, reached out to Laura while in the hospital following a suicide attempt. She learned that Laura, a 34-year-old member living in the rural community of Sargent, did not have a behavioral health provider. Kim located a provider with a therapy office less than 30 miles away. Laura and the provider agreed to an initial in-person appointment, with the option of subsequent appointments via telehealth. Kim connected Laura to one of our licensed BH clinicians who is supporting her with Care Management to monitor and meet ongoing needs.

Targeted Support to Prevent Suicide. For individuals who have attempted suicide, the time directly following discharge from inpatient or emergency treatment increases the possibility of another attempt; however, research shows that by providing timely clinical interventions, that likelihood is significantly reduced.[3] We use, Choose Tomorrow, a Zero Suicide Framework, developed by Centene in partnership with the Zero Suicide Institute. Choose Tomorrow leverages technology to identify members at risk, delivers provider and staff education on evidence-based approaches to screening and safety planning, and tailors communication and care management to connect members to community resources. The initial program was piloted in Washington with children served in the child welfare system. In 2018, our Washington Medicaid

[3] https://pubmed.ncbi.nlm.nih.gov/22846445/

affiliate completed 498 C-SSRS screenings and ***decreased suicide attempts by 8% in their Foster Care, Adoption Support, and alumni population.*** Based on its success, Centene expanded the framework to several states and additional populations, including members who served in the military.

Increasing Awareness of Crisis Support. As the 988 Suicide and Crisis Lifeline dialing code becomes nationwide, we will promote this critical resource where individuals can access confidential 24/7 crisis support via call, text, and chat. We will use SAMHSA's curated toolkit to communicate with members, providers, and community partners about available resources. Any individual can access live, trained, crisis counselors who provide support in areas such as substance use, teen pregnancy, family relationships, depression, anxiety, stress, suicide, bullying, and isolation. 988 call services will be available in Spanish, along with interpretation services in over 150 languages. Active rescues for those with thoughts of suicide are connected to local law enforcement; nationally, these life-saving interventions occur 15 to 20 times per day.

Brave Health. Nebraska Total Care will offer Brave Health, a virtual Community Mental Health Center platform and model providing child, adolescent, and adult psychiatry; therapy; substance use disorder care; hospital transition support; medication adherence intervention; and health navigation services. Brave Health's Psychiatric Navigation Program (PNP) delivers health navigation services by linking members to a navigator for 1:1 check-ins and Solution-Focused Brief Therapy to ensure successful linkage to a psychiatric evaluation. Preliminary outcomes include a ***90% reduction in BH admissions and a 66% reduction in costs for individuals with a Brave Health encounter.*** Brave Health's PNP has an 82% successful completion rate for child psychiatry evaluations, compared to 65% for children without PNP. Brave Health provides a value-based purchasing resource model focused on 7- and 30-day follow-up visits after an inpatient admission to support HEDIS measure improvements and reduce inpatient readmissions.

'Adam' Gets Needed Care and Avoids Readmission through Transitions of Care. A 33-year old member, Adam, was recently discharged from an inpatient psychiatric admission after experiencing significant behavioral health symptoms, including delusions, psychosis, and anxiety. Adam's history of severe psychosis and medication non-adherence were difficult for Adam's mother and legal guardian, Natalie, to manage at home. She had been trying for over a year to get Adam into a residential treatment facility and she was frustrated with her inability to get her son the care he needed. She reached out to Nebraska Total Care for help. Our Care Management team worked closely with Natalie and Adam's physician to quickly transition Adam to an appropriate residential treatment facility within the next two weeks, where Adam then received ongoing treatment and medication adjustments. Once Adam's symptoms improved, he was able to be discharged back to the community. Since then, Adam has not required a psychiatric readmission or ED visit and Adam's Care Manager continues to work closely with Adam and Natalie to ensure he has ongoing access to the treatment and support he needs.

Discharge Planning for Youth

Our transition process ensures safety and mitigates disruptions for children/youth transitioning between care settings, such as an inpatient psychiatric hospital, another facility admission, or discharge home after an inpatient stay or residential facility placement. We employ service delivery innovations to avoid admissions and care setting changes and support in-home placements. Our TOC team immediately notifies our Care Management and Foster Care Specialist teams upon admission to ensure seamless discharge planning and ongoing care management coordination. For BH and SUD issues, our Foster Care team is often involved before admission, working with the Division of Child and Family Services (DCFS) and caregivers to find an inpatient or residential treatment facility. ***Based on our recently developed Child Welfare Dashboard, we know the highest rate of inpatient admissions, at 74%, are for young people ages 12-19 for psychiatric reasons.***

Our approach to discharge planning is a child-centered multidisciplinary process, beginning with assessing the child's current needs at admission to a higher level of care and continuing throughout the stay. Using a strengths-based, trauma-informed care approach, we assess the circumstances that led to the child's placement, strengths and goals, and the barriers or risks to transitioning the child to a lower level of care. Our Foster Care team collaborates with the Division of Child and Family Services (DCFS), parents or caregivers, and the member's ICT, including treating providers, foster care family or agency, and other individuals involved in the child's life, to develop a transition plan. This includes efforts to honor the child's relationships in their current setting and family, when appropriate, and maintain provider-child relationships where possible. When age-appropriate, we encourage the child to lead discussions to develop goals and an action plan to facilitate a successful lower level of care placement. We document screenings, assessments, referrals, treatment records, plan of care, and Care Management notes in TruCare Cloud to inform and guide discharge plan development and confirm arrangements and authorizations for necessary services and supports are in place. Before discharge from the higher level of care, the Foster Care team and the member's assigned Care Manager coordinate to ensure safe placement and that services are in place to meet the child's social and health care needs.

Identify, Refer, and Coordinate Services to the Lower Level of Care. The transition plan identifies essential information about the child and family, including health history, diagnosis, levels of functioning, social, and cultural needs. The transition plan includes referrals to the necessary services and support. We work to overcome any identified barriers to discharge planning, such as alternative care sites and foster home placement. In collaboration with DCFS, we provide the support needed to coordinate access to these services and:

- Identify age-appropriate, culturally sensitive, and relevant goal-directed activities; preferred providers of covered and non-covered services; and barriers to accessing services and supports.
- Refer the child/youth to all needed health care and social services, such as a PCMH for ongoing medical care, a BH provider, and local support for educational, emotional, and SDOH needs.
- Coordinate with DCFS to ensure all necessary follow-up appointments take place as scheduled. Sometimes children readmit to a higher level of care even after comprehensive transition planning. When that occurs, we have processes to provide enhanced support to stabilize the child and family. We work with treatment providers to review established goals and ensure referrals to the appropriate level of care.

Evaluate the Risk of Readmission to Higher Level of Care. Our TOC Team, Foster Care Liaison, and Care Managers coordinate with the child's authorized representative to evaluate the risk of readmission following any hospital discharge or transition from a higher level of care and identify the child's strengths and supports needs and risk factors. Using the information gathered from the authorized representative, recent screenings, ICT feedback, and coordination with DCFS, the member's Care Manager evaluates readmission risk. To support this evaluation, we deploy our suite of predictive analytics tools which consider the child's needs across the continuum of care, including SDOH. Our Centelligence predictive analytic tools examine large data sets daily to identify the readmission risk level. For example, a stay in a psychiatric residential treatment facility indicates that the child has additional risk factors and needs coordinated planning for an appropriate post-discharge placement.

Based on the child's risk of readmission, our team works with DCFS to coordinate services that best support the child in the lower level of care, ensuring that ordered post-discharge services are in place and other needs are met to reduce the risk of readmission. We assess children in foster care as they transition to new placements or age out of the Foster Care System. We have established systems and processes for accepting notifications from DCFS when a child has a change in foster home placement. As part of our person-centered care planning process, a member may always request a reassessment of their plan of care and level of care redetermination at any time. We honor the member's request and perform a reassessment, revising the member's plan of care as necessary. A provider can likewise request a redetermination at any time, and we follow a similar process.

Monitoring Post-Discharge Care of Members in Rural and Frontier Areas

Our TOC team connects members with a local provider if they do not already have one. We partner with community treatment teams to support medication management and adherence for members with SMI. We work with providers throughout the State to support the provision of telehealth services to members in rural and frontier areas to provide discharge services. Babylon Health is one of our on-demand virtual health solutions to support access to PH and BH services, including 24/7 access to virtual care visits for urgent care needs. The platform uses leading-edge digital technology and artificial intelligence symptom-checking tools to triage members and determine the correct point of care.

Through the Babylon platform, members can initiate two-way video and/or audio virtual visits for pediatric and adult urgent care needs, and BH services, including therapy, psychiatric care, prescription management, and preventive care, while maintaining accessibility for members with disabilities or limited English proficiency. Members are connected to virtual care services and monitored or referred to a provider (e.g., ED) should the virtual visit not be appropriate based on their diagnosis. Our technology-enabled solutions enhance access and remove barriers to care such as transportation, medical vulnerabilities, work schedules, childcare, and many other daily challenges that interfere with consistent, meaningful health care access. Our affiliate in Washington offers Babylon and significantly increased access to care, with ***40% of their members using telehealth reporting that without it, they would not have sought care.***

Post Hospital Outreach. We reach out to members within 72 hours of discharge to confirm post-discharge appointments have been scheduled and to verify that ordered services are in place and meeting the member's needs. This could be a home care nurse, delivery of oxygen, or a hospital bed. If the services are not meeting the member's needs, the Care Manager or TOC team escalates the issue and finds resources to resolve it. Support is available, if needed, to assist the member with scheduling follow-up appointments as well as assistance with the arrangement of transportation to scheduled appointments. Other actions during this outreach include:

- Review and reinforce all aspects of the discharge plan and educate the member on their condition, follow-up, and the importance of adherence.

- Medication reconciliation (within 72 hours of discharge) by identifying all the medications the member is taking including over-the-counter medications, verifying if discharge prescriptions have been filled, determining how and when the member is taking the medications, and identifying potential drug interactions or duplications. We educate the member on medications, how to take them, any adverse symptoms or reactions, and when to contact their prescriber and/or PCP. We assist the member in obtaining medications and communicate with our Pharmacy department, the PCP, BH provider, or other provider(s) regarding potential interactions, duplications, or side effects.
- Assist the member in developing an action plan to prevent an avoidable ED visit or readmission (as described in the Readmission Reduction program); obtain provider input and share actions with the PCP and treating providers.
- Assess the safety of the home environment as needed to prevent injuries or improve health status, such as determining the need for handrails in the bathtub or shower, loose rugs, lack of air conditioning, or insufficient food.
- Confirm any needed community services are in place, such as home-delivered meals. If the member has not made the appointments, the Care Manager assists in scheduling and arranging for transportation if needed.
- Connect members with a BH admission/BH peer-to-peer support, or other health-related services, to encourage a strong recovery-oriented plan and adherence to follow-up.
- Communicate with the member's PCP and other treating providers to keep them informed of the member's progress and any needs for new services to keep them safely in their home.

Readmission Reduction Program

We use our Centelligence predictive modeling tools to quickly detect and intervene with at-risk members and members with rising risk, such as members with advanced illness or sickle cell disease. Centelligence generates daily reports that identify members who have been admitted to an inpatient setting, including information on their readmission risk score, the number of readmissions in the last 30 days and within the past year, and the name of their Care Manager and PCP/Patient-Centered Medical Home (PCMH). Our TOC team uses this information to provide pre- and post-discharge coordination and assistance to ensure a successful transition, reduce readmissions, and improve member health care outcomes and overall health status.

Reducing Readmissions

An analysis of the effectiveness of the Readmission Reduction Program across our affiliate health plans found that members enrolled in the program had a statistically significant lower rate of potentially preventable readmissions (PPR) compared to members not enrolled (11.6% PPR and 13.12% PPR respectively).

The interdisciplinary nature of our approach maximizes our ability to identify and address barriers that may have led to the admission, harnessing the varied backgrounds of our UM, Care Management, Pharmacy, and Network staff and Medical Directors through direct conversations, structured case rounds, and information sharing. We document this information in our care management platform, TruCare Cloud, so all stakeholders have a complete, current picture of member needs and services. Using our Centelligence predictive modeling tools, we stratify member risk for readmission to effectively target resources and quickly intervene. The member's readmission risk level considers the member's diagnosis, SDOH needs, and other non-medical risk factors, driving which staff members are involved in transition planning and follow-up, coordination with hospital providers and other treating providers, and the service intensity. We prioritize member outreach using our Readmission Prevention Model, which assigns a probability of readmission to the member at the time of hospital inpatient admission. This process maximizes TOC staff/Care Manager efficiency by directing resources to members most in need. As part of our model, our prevention standards include:

- Follow-up appointments for BH within 7 and 30 days
- Pharmacist conducts medication reconciliation, shown to contribute to readmission reduction [4]
- Addressing DME, home health, private duty nursing, and therapy needs
- Effective communication with the member's Integrated Care Team (ICT) includes the member, the member's PCP or PCMH, the hospital provider, and other treating providers involved in the member's care

Members at High or Moderate Risk of Readmission. Care Management staff visit with the member (either via phone or face-to-face) before discharge to assess status and needs and provide education. As part of our process, Care Management staff communicate with the member, caregivers, attending physicians and inpatient providers, PCP, and any outpatient providers to look beyond the discharge orders. This information is used to determine the member's holistic needs post-discharge and develop a plan to return the member to the optimal setting for health and wellness. Specific hospital

[4] Pesch, Lucie; Stafford, Terry; Hunter, Jaclyn; Stewart, Glenda; Miltner, Rebecca Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic, Journal for Healthcare Quality: May/June 2022 - Volume 44 - Issue 3 - p 123-130

discharge and transitional support activities include:

- Evaluating PH, BH, and SDOH needs and coordinating care and services during level of care transitions
- Assessing transition needs and documenting in a transition plan (further described below)
- Supporting referrals and scheduling assistance for timely follow-up appointments, specialty care, transportation, medical supplies and equipment, and other supports
- Verifying medications before discharge and confirming the member's access to medications
- Reconciling medication, as appropriate
- Transferring member records in compliance with HIPAA privacy and security rules, including providing a copy of the discharge plan to the PCP/PCMH and other treating providers
- Contacting the member within 72 hours of discharge to assess status, confirm receipt of services, and evaluate the effectiveness and appropriate use of supplies and equipment
- Arranging same-day hospital discharge transportation assistance
- Arranging post-discharge meals for members who are food insecure or with post-discharge dietary needs
- Providing members in Care Management with NICU Kits and Sickle Cell Kits, as appropriate, based on the member's situation to prevent readmissions.

Developing a transition plan specific to the transition period is a best practice in reducing readmissions. Incorporating all elements described above, we develop transition plans that reflect member strengths, preferences, and post-transition goals. The transition plan remains in place until all post-discharge needs and barriers have been addressed and includes an individualized emergency backup plan for services as needed. The emergency backup plan documents specific actions members or their caregivers can take if they experience a barrier and includes explicit directions for reporting any gaps in services. We document the emergency backup plan in TruCare Cloud to facilitate Care Coordination.

Members at Low Risk of Readmission. For inpatient facility admissions, we coordinate the discharge plan with hospital staff and attending providers, and help identify network providers to deliver post-discharge services. We reinforce with the member and applicable caregivers the importance of:

- The discharge orders and the need to take them home/share with follow-up providers
- 7- and 30-day follow-up appointments and assistance to make the appointments
- Listing and reviewing with the member and representative all medications with the name of the drug, dosage, frequency, and prescribing physician
- Filling any newly prescribed medication(s) and asking attending physicians for clarification on taking previously prescribed medication(s), ensuring no contraindications with medications
- Arranging same-day hospital discharge transportation assistance
- Informing the provider or plan if ordered services have not been provided timely

61. Describe how the Bidder will use data and evidence-based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care management for members, improve outcomes, and create cost efficiencies. Discuss how these tools, data, and systems will be integrated to implement outcome- and value-oriented payment models. Describe the Bidder's experience and specific results.

Page Limit: 5

Using Data and Evidence-Based Decision Support Tools to Impact Service Delivery

Nebraska Total Care thoughtfully uses data and evidence-based decision support tools to improve the overall population health of Nebraska. Data increases communication across system partners and internally, enabling us to establish shared Care Management, health outcomes, and cost goals. As an NCQA-accredited and quality-driven organization, we apply a systematic approach to program improvement, using reliable and valid monitoring, analysis, and evaluation methods. Our Health Equity and Diversity Committee, Quality Assessment and Performance Improvement Committee, and Clinical and Population Health Management (PHM) Committee evaluates and integrates information on health disparities, health outcomes, and member experience. The Committees review and monitor clinical performance, HEDIS measures, quality indicators, utilization, and member engagement; and identify and solve for opportunities and barriers across populations and sub-populations on an ongoing basis. For example, after we complete our yearly PHM quantitative analysis, a multidisciplinary group that includes members of the Quality Assessment and Performance Improvement (QAPI), Care Management, Utilization Management (UM), and Provider Relations departments; and provider stakeholders conduct a thorough qualitative analysis. The group brainstorms barriers to improved performance, selects opportunities for improvement, and initiates actions to improve performance and member experience. We develop a detailed action plan to address opportunities and monitor progress towards meeting goals. We report annual assessment results, combined with updated population needs assessments and other data inputs described above, through our QAPI committee structure and Board of Directors, driving the next year's Care Management program planning, strategy, and resource modifications.

Nebraska Total Care continuously evaluates structure, process, satisfaction, quality, and clinical outcome measures to monitor success and modify programs and interventions as needed. We use our 2021 NCQA Innovation Award-winning Health Equity Model to drive Care Management service improvement and innovation. Our model includes a four-step, data-driven process to identify health disparities and develop, implement, and evaluate equity-focused interventions, as shown in **Figure 61.A**.

Figure 61.A Our Health Equity Improvement Model Drives Improved Care Management Services.

Nebraska Total Care integrates health equity and disparity data analysis into our overall Care Management program, working to improve health outcomes for every member we serve. To identify disparities, we analyze various sources, including:

- Internal dashboards powered by our Centelligence reporting and analytics platform
- Our proprietary Neighborhood, Economic, and Social Traits (NEST) predictive modeling tool
- The State-wide Health Information Exchange (HIE), CyncHealth
- State registries
- The Prescription Drug Monitoring Program data
- HEDIS and CAHPS data
- Grievance and appeal data
- Performance Improvement Project (PIP) data
- Qualitative data related to the experiences of members, providers, and stakeholders

We leverage publicly available reports from our State partners, Nebraska Healthy People 2030, and the Office of Health Disparities & Health Equity 2021 Report. Using logistic regression models, we stratify data using reported race, ethnicity, and language. For members where we do not have this data, we use data-driven technologies and local demographics to reliably attribute race and ethnicity, which has a validation rate of over 80%. This reliable attribution model uniquely

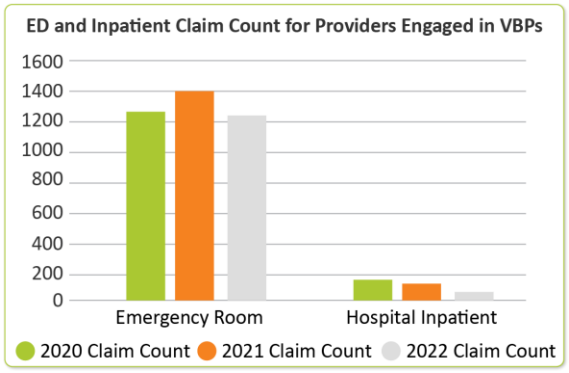
positions us to accurately identify disparities experienced by different subpopulations using high validity race/ethnicity data for 100% of our adult membership. We overlay these analyses with additional data and demographics to identify and observe how variables such as poverty, rural geography, disability, gender, and SDOH contribute to disparities. We then implement specific solutions and strategies to address disparities. ***For example, our food insecurity project with Fork Farms hydroponic gardens specifically impacts two Nebraska communities with identified food deserts and high percentages of children receiving free or reduced-cost lunches by providing fresh, healthy food to school children and their families.***

Data Transparency. All Care Management staff involved with the member have access to a single source of truth through our care management platform, TruCare Cloud. This ensure services are not duplicated and the member receives optimal services to improve health outcomes. We make Care Management information available on our secure Member, Provider, and Community Partner Portals, allowing members and the multidisciplinary care team to access relevant Care Coordination data.

Centelligence Predictive Modeling Tools. We use our Centelligence proprietary predictive modeling and analytic tools to systematically monitor, stratify, and continuously identify members at current or future risk. We use Centelligence to track and trend data, inform Care Management activities, and support improvement planning and evaluation. We use our targeted predictive models to identify potential risk factors related to SDOH, substance use disorder (SUD), diabetes, ED visits, readmissions, and other defined categories. For example, our Opioid Risk Classification Algorithm stratifies members at risk for opioid misuse and abuse before a diagnosis using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. ***Our Opioid Risk Classification Algorithm model has a positive predictive accuracy rate of 98% and since its inception in 2017, has increased the identification of members with opioid use disorder by over 150%.***

Our proprietary tools allow us to view health equity data at the sub-population level, including review by race, ethnicity, language, disability status, and geography. Our models offer Care Management staff and providers actionable, forward-thinking, and member-centric data to guide decisions and ensure appropriate management of resources. We monitor clinical information and evaluate member needs and progress, using predictive models to deploy resources and initiate targeted actions. For example, Nebraska Total Care data analysts have access to a clinically-validated predictive model enabling us to identify members at risk of loneliness and social isolation. Once we identify a member who is at risk for loneliness, our Care Management staff confirm social isolation or loneliness and prioritize members for the ***Friendly Voices*** program with the highest scores. The Friendly Voices program links local community-based volunteers that can facilitate ongoing calls with members facing social isolation who would like more social contact, creating meaningful connections.

Figure 61.B Using Data to Impact Member Outcomes



We also leverage our predictive modeling tools when we meet monthly with providers engaged in Value-Based Purchasing (VBP). During these meetings, we discuss the management of members with high risks, identified through predictive modeling. These sessions include employees from the Nebraska Total Care Case Management team and the member's PCP to discuss strategies to reduce potentially preventable events, improve member care and create cost efficiencies. Our efforts to leverage data and engage providers to reduce ED and inpatient claims, as shown in **Figure 61.B.**

Using Data When Working with Providers and Stakeholders. Centelligence tracks performance measures over time and analyzes trends against goals for clinical and operational areas, allowing providers to compare HEDIS and other quality/cost metrics to industry and state standards and their peers through our Provider Analytics solution. To improve clinical outcomes, we provide an actionable, detailed breakdown of data so providers know which assigned members to contact, for what services, and by when.

Clinical Decision Support Tools. We include InterQual criteria in TruCare Cloud to assist Utilization Review Clinicians in making appropriate medical decisions based on nationally-accepted, evidence-based standards of care. We incorporate program-specific clinical practice guidelines to ensure review practices align with State standards.

We also use evidence-based assessment tools, including our Health Risk Screening, Health Risk Assessment, Homeless Identification form, and condition-specific assessments such as the PHQ-9 for depression, the CAGE-AID for SUD, GAD-7 for anxiety, the Vanderbilt Self-Report for attention-deficit/hyperactivity disorder, the Columbia Suicide Severity Rating Scale

for suicide risk, and the Screening, Brief Intervention, and Referral to Treatment screen to drive appropriate Care Management interventions and ensure a member is receiving services at the right service level.

Provider Analytics. Available through our secure Provider Portal, Provider Analytics brings together actionable and timely clinical and administrative data. This helps staff and providers identify and prioritize member outreach based on clinical needs and opportunities and understand the next best actions to improve population health, such as outreach, education, or Care Coordination. Provider Analytics fosters partnerships between our staff and providers to ***enable effective cost management and quality improvement activities while optimizing providers' performance in Pay-for-Performance (P4P), shared saving, and risk contracts, when applicable***. From the cost, utilization, and quality measures to value-based member engagement and PCP loyalty data, Provider Analytics delivers interactive data for providers. Providers can use custom selection, drill-down, data exporting, and reporting capabilities to identify clinical and cost performance factors and strategically target clinical actions. Data visualizations also make information accessible and actionable for users. Key measures include:

- **Creating Cost Efficiencies.** On the summary landing page, providers can see how their actual PMPM compares to peers, on a risk-adjusted basis. Providers can view cost and historical claims data; see their performance across primary care, specialty care, inpatient, outpatient, Emergency Department (ED), pharmacy, lab, and other areas; and how they compare to their peers across major practice categories.
- **Improving Quality.** Providers can evaluate their quality performance using two main criteria: measure or NPI. Each can be evaluated using top non-compliant count, top complaint count, and top compliant rate. We enhanced the quality measure tool to include 100+ new measures, boosting performance monitoring.
- **Promoting Engagement and Loyalty.** We know that services rendered by a member's assigned PCP can result in better care, lower costs, care gap closures, and better overall member health. Therefore, we help providers and staff track how frequently this is happening. The summary landing page contains an engagement analysis that classifies member interactions with PCP services into two main categories - provider engagement and provider loyalty. Engagement measures the provider's efficacy in engaging assigned members to be seen for a primary care visit annually, while loyalty measures the provider's ongoing efforts to maintain exclusivity as the PCP for their assigned panel of members.
- **Increasing VBP.** As providers shift to VBP contracts, the availability of such data to determine contract performance is paramount, and Provider Analytics enables providers to monitor their performance versus contractual or bonus goals. Providers can view quarterly financial views, all the measures in their VBP program, targets, current score, and the number of gaps needed to close to reach the highest target. Providers can view the top measures with the highest amount of unearned dollar potential, the number of members needed to reach the maximum target, and information to understand the calculation of their bonus. Provider Analytics enables providers to pull actionable reports to identify members needing care gap closure tied to their VBP measures.
- **Reducing Admissions and Readmissions.** Providers can see a high-level view of the number of admissions and readmissions and overall admission and readmission rates. All providers can drill down into admissions and readmissions by disease and facility.

Sharing SDOH Data with VBP Providers. We hold Care Coordination meetings with VBP provider groups monthly to discuss members with high utilization and complex needs. We work as a team with the provider to address PH and BH needs and social needs like homelessness and food insecurity and then link those members to the appropriate community-based resources.

Integrating Data Tools and Systems into Outcomes and VBP Models

We leverage our full capabilities in managing VBP contracts and accounting for results. We apply data science and analytic techniques to assess a member's risk for developing adverse health outcomes, and other predicted health behaviors. Predictive analytic tools enable us to develop targeted VBP strategies and communicate rising risks to providers so they can meet VBP performance measures.

Individualized Support Through Dedicated Staff. We have dedicated staff and roles specifically to support the success of our VBP providers. Our ***Strategic Provider Partnership Director and Strategic Provider Partnership Manager*** meet regularly with providers for actionable data sharing and Care Coordination to ensure they succeed. ***Quality Practice Advisors*** provide care gap closure, appropriate coding, and HEDIS education to providers to maximize quality outcomes for members. Our ***dedicated staff*** monitor provider performance; educate and train providers on the drivers behind their performance; assist with HEDIS reporting, using our Care Management programs and web-based tools; identify practice-specific care gaps, and provide recommendations for improvements. Our highly responsive, community-based team helps mitigate any issues immediately.

Community Investment Agreements and Data Sharing. Our Provider Relations team builds relationships that lead to

outcomes-based contracts, including bidirectional member-level data sharing and required reporting on health and social indicators. Providers under VBP contracts share supplementary datasets which provide additional details on members that are not sent via a claim. Eight high-volume VBP contracts representing over half of the Nebraska Total Care membership share this data with us at least quarterly. Community partners involved in a member's care can gain secure access to our Community Partner Portal to share and access key member demographic and clinical information bi-directionally. Authorized users can view up-to-date care gaps and member health record data, including dental and medical information such as immunizations, pharmaceutical information, allergies, and labs; upload key documentation and assessments; view care plans; and create free text and structured notes, among other functions.

Our Provider Portal also includes our ***Patient Analytics Dashboard***, which enables providers to access chronic conditions registries, gaps in care, opportunities to improve outcomes, PH and BH diagnoses, medication, lab, and care team data. We also make hospital admission, discharge, and transfer (ADT) notifications from CyncHealth securely available to providers via our secure Provider Portal, assisting our hospitals with notifying providers of hospital events.

Addressing Whole Health in VBP Models. We build SDOH measures into our VBP approach, specifically through our SDOH and Health Equity VBP model. We develop a study design, outcomes measures, and measurement protocol for each intervention, controlling for population and environmental variables, and assess the ability to leverage process improvements at scale, supporting the greatest number of members possible. When we develop a community-based organization (CBO) contract, we identify metrics that have value to all parties and begin a dialogue by identifying data that CBOs already collect for other funding sources. Often, we do not need to ask them to track additional data, avoiding administrative burden. Outcomes used within our VBP contracts include homeless days impacted, ED utilization, healthy births, food stability, and inpatient admission. For example, ***Nebraska Total Care is establishing an SDOH P4P program as part of our overall Value-Based Purchasing approach.*** Through the SDOH P4P program, providers will administer a two-question evaluation tool (Hunger Vital Sign), based on the US Household Food Security Scale, to identify children in households at risk of food insecurity. To identify homeless or under-housed members, providers will administer a two-question Housing Screener adapted from the CMS Health-Related Social Needs Screening Tool. The provider will then submit diagnosis codes such as Z59.0 (Homelessness) or Z59.1 (Inadequate Housing) to receive an incentive payment. Providers will refer members with identified needs to a CBO and document referrals in Findhelp. Providers will notify our Care Managers of identified SDOH barriers to facilitate member outreach.

Value-Oriented Payment Models Improve Outcomes

Supported by data-sharing, providers engaged in Nebraska Total Care value-based purchasing models showed improved HEDIS rates from 2020 to 2021:

- Breast cancer screening
- Childhood Immunization Combo 10
- Controlling High Blood Pressure (<140/90)
- Immunization Adolescent - Combo 2
- Lead Screening for Children
- Well-Child Visits in the First 15 Months of Life - 6+ Visits

Nebraska Total Care's Experience and Specific Results

We have significant experience in VBP across our provider network and have pioneered the VBP model in Nebraska, working closely with State partners. Our payment models recognize regional variations in local health care systems, particularly in rural, frontier and urban areas, and include initiatives that reflect the availability of services and challenges providers face in their community. Our strategy builds local collaborative environments to identify providers' strengths and weaknesses, maximize their skills, and incentivize the development of innovative ways to improve health care delivery and create true partnerships with members. Our success depends on strong partnerships with providers, investments in actionable data, and high-touch technical expertise that supports provider success.

P4P Primary Care Incentive Model. The P4P Primary Care Incentive model provides a performance incentive that encourages appropriate and timely preventive health and disease monitoring services, per evidence-based clinical guidelines, and incentivizes provider outreach to members. Providers access HEDIS reports from our business intelligence tools via the provider analytic portal to inform member engagement and quality gap closure. This program is available to all PCPs who are within a group that has 50 or more assigned Nebraska Total Care members. P4P includes an annual HEDIS bonus for members enrolled that meet or exceed HEDIS measures. P4P participating providers doubled their earnings as a result, achieving their quality benchmarks from 2019 to 2021.

Care Gap Closure Program for Integrated Risk Adjustment. The Care Gap Closure program supports PCPs in engaging members with chronic conditions such as diabetes or chronic obstructive pulmonary disorder to close care gaps. Our Risk Adjustment team performs risk analysis on a member list to determine predictive and prescriptive groups. Providers review their assigned member list and a checklist of identified gaps and work to close them, improving member health outcomes. Providers log in to the Provider Portal to obtain the checklist, check off tasks as they close gaps, or bill a claim. This process captures members' diagnosis codes which factor into the overall risk adjustment. This program has resulted in a 62% increase in Providers actively working to engage members in care gap closures.

Value-Based Purchasing Quartet Pilot. Centene and Nebraska Total Care have partnered with ***Quartet*** to provide data analytics reporting and support for the implementation of this model with two providers: CenterPointe in Lincoln and Community Alliance in Omaha. Quartet provides ongoing reporting and feedback on performance by analyzing claims data and assessment information captured in their platform. Quartet supports incentive-based contracting for engagement and assessment and direct outreach to assigned members. Quartet is the reporting and data capture platform that supports our two BH VBP contracts based on provider engagement, assessment, and community tenure. Quartet works with the providers monthly to share reports and member progress, review data, identify incentives earned to date, and support the ability to further member engagement and progress. Quartet also has a member referral capability for our BH VBP providers, supporting direct Care Management referral to these providers, and is another optional incentive for timely referral acceptance. ***Community Alliance met treatment initiation measures for 20 members and achieved community tenure targets.***

CenterPointe Pilot

CenterPointe began participating in our P4P BH Pilot model in October 2021. CenterPointe uses the initial eligible member list shared by Quartet to identify which members they want to prioritize for outreach and engagement. CenterPointe saw success with engagement by first providing community support and SDOH services, which increased member engagement in therapy and psychiatric services. CenterPointe has achieved the following for 23 engaged members:

- $1,070 in treatment Initiated bonuses as of Q4 2021
- $370 in treatment Initiated bonuses as of Q1 2022

"My team and I appreciate Nebraska Total Care putting in the time to build relationships, correct problems, and initiate new payment structures in mental health and substance use. Specifically, I want you to know that we are proud to be working on a value-based contract with Nebraska Total Care and Quartet that focuses on people in our community who struggle the most and need an intensive approach to find a positive solution. We believe our collaborative is groundbreaking and results in positive outcomes for all concerned. We also appreciate you continuing to apply effort to smooth out authorizations and claims payments when they are delayed. It is critical that these processes run smoothly for our effective business performance and cash flow."

- Topher Hansen, JD, President and CEO, CenterPointe

NEMT Pay for Performance Program in Lincoln/Omaha. We launched a new NEMT P4P program in October 2021. Nebraska Total Care partnered with high-volume NEMT providers in Douglas, Lancaster, and Sarpy Counties, and established a driver incentive/pay for quality program based on data gathered from complaints. Each provider has individualized targets that can earn an incentive when reached, as well as a county impact incentive that can be earned based on complaint reduction thresholds. The results from the fourth quarter of 2021 and the first quarter of 2022 show 20%-50% decreases (based on impact area) in all driver complaints.

Equity-Based Contracting (EBC). We are investing in and engaging providers by adding Equity-Based Contracting (EBC) as a new dimension to our VBPs and funding under-resourced providers with a new health equity incentive based on population risk level. We assess HEDIS metrics by race and ethnicity groups, rural and urban populations, and age groups to identify health disparities and develop provider incentives to address them. For example, using the NEST tool, we have identified inequities in care for members in Scottsbluff, North Platte, and Omaha. In response, we selected providers who deliver high-value care and with whom we have strong relationships to pilot our EBC model - Great Plains Health, Community Action Partnership of Western Nebraska, Children's of Nebraska, and OneWorld. Using lessons learned from the pilot program, we will expand EBC statewide to drive equitable access to care for all members.

62. Provide a proposed plan for coordinating efforts for members who may be involved in multiple State programs, including those enrolled in HCBS waivers.Describe how the Bidder will deploy care management activities under this RFP in a manner that will not duplicate the activities provided under HCBS waivers and will facilitate sharing of information across DHHS-administered programs.

Page Limit: 3

Proposed Plan for Coordinating Efforts for Members Involved in Multiple State Programs

Nebraska Total Care promotes a person-centered, holistic approach to health and wellness collaboratively through data sharing while avoiding duplication of services. We coordinate with the member and their family, providers (including providers of home and community-based [HCBS] services), and other State programs, such as those provided by the Division of Children and Family Services (DCFS), the Division of Behavioral Health, and the Division of Developmental Disabilities (DDD), to facilitate information sharing. For example, Joni Thomas, our Community and Disability Liaison, provides consultation to Nebraska Total Care staff on waiver and disability issues, serves as the point of contact with DDD, supports member's care teams, and provides internal staff training on available State resources and how to assist members in accessing them.

We will expand our approach, working with State and system partners to design and adopt an enhanced reciprocal process that works for each partner. We offer our proposed plan for Collaborative Agreements to strengthen and streamline efforts for members involved in multiple State programs. We will work with each State partner to establish formalized Collaborative Agreements that address the following elements:

- Designated staff at Nebraska Total Care that will serve as points of contact for each agency
- Joint processes for identifying member needs and streamlining referrals for resources and services
- Data sharing agreements and processes that allow us to share member information securely bi-directionally
- Training for Nebraska Total Care and State agency staff on available benefits and services, eligibility, key processes, and best practices in Care Coordination
- Processes for coordinating care and supporting members with complex needs
- Monitoring systems to determine the effectiveness of our Care Coordination approach and ongoing communication

Assignment of Key Point Persons. ***Nebraska Total Care is hiring a dedicated System of Care Liaison who will work in concert with our Community and Disability Liaison and Foster Care Liaison***. These staff are the dedicated point persons for their identified State agency or program. These positions anticipate and resolve systemic coordination and communication issues to quickly meet the needs of HCBS waiver providers, DCFS, or other State programs, ensuring timely care for members. The liaisons meet regularly with entities associated with waiver services to develop best practices to support members at the plan level and coordinate waiver services. They provide education on Nebraska Total Care processes and support system partner staff using our data sharing tools such as the Community Partner Portal. The liaisons will develop Collaborative Agreements that outline our procedures for coordination and participate in training on the members involved in multiple State programs.

Referral and Identification Processes. Nebraska Total Care identifies which members are receiving HCBS or DCFS services, and we add this information to our member roster using a dedicated database. We proactively identify members needing HCBS services through the 834-enrollment file, claims data, waitlists, and referrals. We coordinate with the member and family, the member's Primary Care Provider (PCP), Behavioral Health (BH) clinician(s), and others through multidisciplinary care teams to assist in accessing HCBS services, including referrals to HCBS providers based on the member's needs, and address any barriers to care.

Care Coordination to Avoid Duplication

To facilitate effective Care Coordination, our Collaborative Agreements will outline the steps Care Managers, social workers, and other staff will take related to communication, member outreach and engagement, care planning, and ongoing service delivery. In instances where a member has a Case Worker, Social Worker, or Service Coordinator outside of Nebraska Total Care, we hold joint care conferences to support members with complex or special health care needs. For example, we will describe our Care Manager's role in communicating with our State partners to coordinate member care, regardless of which program or State agency provides the benefit or service. As an ongoing resource, our Care Managers:

- Support all State agencies and external entities in coordinating with one another (for example, Personal Assistance Services, respite providers, and early intervention providers).
- Hold regular care team meetings with system partners and providers
- Facilitate electronic connection and health information sharing through our secure Community Partner Portal
- As needed, assist the State agency or external entity representative in gaining access to the Community Partner Portal
- Document services and support in the member's plan of care

Coordinating Care for Members Enrolled in HCBS Waivers. We coordinate care with HCBS Case Managers as needed without duplicating members' plans for services and support through joint care conferences. Per MLTC requirements, Nebraska Total Care submits policies and procedures related to Care Coordination with HCBS Case Managers for review and approval at least 60 calendar days before implementation. We may identify members needing HCBS during our initial or ongoing assessment processes. When we identify these needs, the member's Care Manager educates the member, PCP, and formal and informal support regarding the availability of HCBS through the HCBS waiver program and how/where to apply for eligibility. Our Care Managers work with the member, family, caregivers, formal and informal supports, the PCP, and other treating providers to develop a plan of care while the member is on the waitlist. To ensure members' needs are met during the waiting period, we have developed relationships with local community agencies that provide interim services and support. For example, many local churches provide volunteer companion and respite services, as do some senior support groups. ***Our Care Managers use Findhelp to identify and close the loop on referrals*** to community-based services and fulfill members' needs beyond what family and friends can provide.

Our Community and Disability Liaison and System of Care Liaison help identify additional support systems, including other Medicaid waivers, as possible options to meet member needs. They educate members and providers to ensure they understand how to apply for benefits and help initiate that process, allowing members to maximize available benefits.

Coordination of Care for Children in Foster Care. Nebraska Total Care has established policies and procedures for case management collaboration with DCFS for children in foster care. Our Foster Care Liaison supports Care Managers in promptly ensuring that children in foster care receive appropriate EPSDT services and age-appropriate initial and follow-up health care screenings and evaluations. Together they directly support providers; identify and close system of care gaps and barriers; share current and relevant health care information per Federal and State regulations; advocate; facilitate linkages between the health care and community-based service systems; and provide technical assistance and support to the member, authorized representative, and DCFS caseworker. Our Foster Care Liaison works with DCFS to coordinate care for children in the Foster Care system. We assist DCFS caseworkers, foster parents, and the foster member in achieving optimal member health and assure continuity of care as the member moves through the child welfare system. We assist youth in successfully transitioning out of the child welfare system by identifying appropriate support services. ***Our efforts to coordinate care with foster youth and DCFS have proven effective: members in foster care had the highest Care Management intervention rate amongst our membership at 35.9% and from 2020 to 2021, we saw a 13.0% increase in PCP visits for foster youth.***

Foster Care Center of Excellence

In 2020, we began a partnership with Children's Hospital and Medical Center (CHMC) to create a Foster Care Center of Excellence to facilitate access to primary care, dental, and BH services for this at-risk and vulnerable population. ***Following the six-month pilot period, our analysis shows that members referred to this clinic have 50% lower ED utilization compared to other providers.***

Our Care Management team creates member-centric plans of care in collaboration with the member (if age appropriate), their DCFS caseworker, and foster parent. Plans of care consider all the child's health care needs, including medical, BH, dental health, and pharmacy. We assess and reassess children in foster care as they transition to new placements or age out of the Foster Care System and provide outreach to close any EPSDT or care gaps. When necessary, we execute single case agreements with providers affiliated with or employed by the State or County Foster Care System to ensure comprehensive continuity of care for children in foster care.

Bi-directional Data Sharing

We recognize a need for refined and efficient data sharing beyond member demographics. Through years of relationship building with our State and system partners, we have identified specific components of an agreement that we will suggest to each State program that impacts the members we serve. Formal data sharing agreements with HCBS providers and DCFS will allow appropriate access to the Community Partner Portal, giving us and our State and system partners line of sight on members engaged in multiple State programs. In addition, beginning in 2023, we will receive Continuity of Care Document (CCD) data through CyncHealth, which will mitigate the need for providers to manually retrieve medical charts and other documentation for our HEDIS quality monitoring.

Facilitating Information Sharing Across DHHS-Administered Programs. Our Corporate Interoperability team gathers nationwide best practices and identifies strategic partnerships with entities from our affiliates in 30 states, such as Availity, to meet interoperability and clinical data sharing needs. This partnership at the local and national levels has prepared Nebraska Total Care to continue our tradition of collaboration and engagement with the State and other stakeholders to advance technological adoption in Nebraska. Our community partners can gain secure, HIPAA-compliant access to our Community Partner Portal to bi-directionally share and access key member demographic, clinical, and Social Determinants

of Health data to use in their engagement with shared members. With member consent, authorized users can securely view up-to-date care gaps and health record data (for example, immunizations, pharmaceutical information, dental, allergies, labs); upload key documentation and assessments; track plans of care; and create free text and structured notes, among other functions. Data-sharing agreements will allow for shared member demographics and plans of care, and other key data, including provider information, prescription data, and diagnoses via the Community Partner Portal. We load member records from State and system partners into our member, provider, and Community Partner Portals, making them readily accessible to caregivers, providers, and HCBS waiver providers. All providers involved in the member's care can view the information, promoting Care Coordination and supporting a collective focus on a single set of goals.

Promoting Data Sharing

We participate in the Nebraska Health Information Initiative and are connected to the statewide health information exchange, CyncHealth, to support care teams with more real-time member information based on ADT data. We added a "Recent ADT" indicator to alert providers who check member eligibility through the Provider Portal. We will leverage dental data from CyncHealth to help providers manage dental health.

Nebraska Total Care incorporates data from State and system partners into TruCare Cloud, our collaborative Service Coordination and Utilization Management platform, which houses the health risk screening, health risk assessment, and integrated plan of care. Our Care Manager acts as the hub for this information, ensuring service and care plans from other entities are integrated into the member's plan of care, avoiding duplication of services.

Staff Education. A key component of our proposed plan is ensuring that staff from Nebraska Total Care and the State agencies with whom we coordinate clearly understand the processes and policies to which each partner entity must adhere. We will suggest joint training on durable medical equipment, authorizations, and aging out of the Foster Care System to promote greater understanding for member-facing staff. For example, we will ask DCFS and HCBS provider offices to educate our team on waiver responsibilities and covered benefits. Similarly, we will provide informational materials and offer training (via webinars, virtual, and live sessions) on the benefits and services available through Nebraska Total Care and how our partner entities can help members access them. We will offer training and education on clinical best practices and tools that support member engagement and Care Coordination. Through monthly meetings with State partners, we will solicit feedback and use this insight to inform policies and procedures for collaboration with the DCFS and HCBS providers and create care tools, like toolkits and resource guides.

Monitoring and Evaluation

We regularly meet with Area Agencies on Aging and Centers for Independent Living, such as the League of Human Dignity, to mitigate issues, share best practices, and improve our collaborative processes. We will hold monthly meetings with each State partner and system engaged in a Collaborative Agreement to review trends, member enrollment, and opportunities for improvement. For specific initiatives, we use Plan-Do-Study-Act (PDSA) cycles to monitor outcomes closely and ensure process improvement agility. We will identify metrics that have value to all parties and begin a dialogue by identifying data our partners are already collecting for other funding or oversight sources. Internally, we monitor the success of interventions; share this data with our State and community partners, members, and providers; and listen to members and the community to appropriately modify, refine, or replace interventions as necessary. The following member story illustrates how we coordinate care with State agencies to better serve members.

Coordinating 'Tim's' Care. Tim is a young man diagnosed with an intellectual disability, schizoaffective disorder, and bipolar disorder. He was living with his mother, but was becoming increasingly aggressive and needed additional support to maintain his and his family's safety and wellbeing. Tim's Care Manager and the Community and Disability Liaison joined Tim and his mother at several meetings with a representative from the Region Three BH Services, the Department of Child and Family Services, the Independence Rising Independent Living Advisor, and the DDD services coordinator. Together, they were able to secure priority funding from DDD, which assisted Tim with securing appropriate housing. Tim now lives in a group home and gets the behavioral support he needs. His mother now reports that she can 'be his mom again' and Tim is looking forward to 'getting a job' and that he 'loves his independence'.

63. Describe the Bidder's outreach program to encourage women to seek prenatal services during their first trimester of pregnancy and how the Bidder will implement required health risk screening and follow up, when applicable, for pregnant members. ***Page Limit: 2***

Encouraging Members to Seek Prenatal Services through Outreach

Addressing Maternal and Child Health

Nebraska Total Care works to provide compassionate, quality care to pregnant members and their babies. Our award-winning Start Smart for Your Baby® (Start Smart) maternal and infant health program provides proactive outreach, Care Management, and health education to support pregnant members from prenatal care through their child's first year. We conduct outreach within 24-48 hours of enrollment or notification of pregnancy, exceeding contract requirements, to ensure that prenatal care begins in the first trimester. Nebraska Total Care's comprehensive strategies for engaging pregnant women, described in our Marketing Plan, include in-person contacts, tailored communication, and leveraging community agencies and providers.

Outreach Strategies. Our ***Member Care Compass*** engagement model utilizes a multi-faceted approach to engage members in preventive care, wellness services, and self-management strategies. Our assertive approach includes home visits, Member Connect Stations, and multimodal outreach, including social media, email, text, written materials, telephonic outreach, Member Portal, and our MyNTC Member Mobile App. We offer appointment-scheduling assistance and appointment reminders to ensure pregnant members regularly attend their prenatal visits, including three-way calls with the member and provider, and assist with arranging transportation, ensuring members can get to their appointments. Additional outreach strategies include:

Proactive communication. Our Care Managers perform outreach to members identified as pregnant based on eligibility files, claims, and utilization data, health risk screenings (HRS), and member or provider submitted Notifications of Pregnancy (NOPs). They are supported by our Start Smart team, comprised of licensed RNs, social workers, and Program Coordinators focused solely on outreach. We continue to conduct outreach—typically three attempts within the first seven days of enrollment or notification to engage members in prenatal care and Start Smart Care Management support, if our initial attempts are unsuccessful.

Reducing Maternal and Child Health Disparities

For many Black, Hispanic, and/or impoverished mothers, inadequate access to quality care and institutional bias impacts their pregnancy. We work to ensure equitable access to prenatal care. From 2018 to 2021, our members demonstrated an increase in prenatal visits:

- 15.1% increase overall
- 17.0% increase among Black members
- 13.4% increase among Hispanic members

In-Person Contacts. Nebraska Total Care offers members a home visit by a Care Management staff to address Social Determinants of Health (SDOH) needs, review benefits, and complete the HRS and the NOP. The visit includes translation services, as needed. This helps build rapport, engage members, and increase HRS and NOP completion rates. We engage pregnant members face-to-face with our ***Community Health Workers*** (CHWs). These field-based staff live and work across the State, offering culturally tailored and concordant services. They address care gaps and support providers and Care Management staff in connecting members to prenatal care.

Tailored Communication. We engage members through a proactive outreach campaign that includes calls, texts, emails, and mailed health education materials about the importance of NOP and HRS completion, prenatal care during the first trimester, care throughout pregnancy and post-partum, and newborn care. We provide culturally relevant referral materials through Start Smart to community groups, faith-based organizations, and our system partners (for example, Community Action Partnership, Salvation Army, WIC offices, and shelters). Our Start Smart program provides prenatal education, referral to the appropriate level of Care Management, and post-partum/newborn health education. Our member materials and other communication are culturally relevant and written at a 6th-grade level for easy comprehension. In addition, we offer a Start Smart mobile application. It provides pregnancy-related on-demand information and support and interactive tools, such as the ability to track personalized pregnancy milestones and informative podcasts.

Community Agencies and OB/GYN Providers. Start Smart staff assist members in accessing OB/GYN prenatal care within our provider network and ensure OB/GYN providers coordinate care with the members' Primary Care Providers. The Start Smart staff provides whole-person education on health care needs, assists with social needs and concerns, and coordinates referrals to appropriate specialists and other services, such as specialty Behavioral Health (BH), dental services, and community resources. Our Start Smart team contacts their providers and pharmacies, reviews claims information, and leverages community partners to support outreach efforts for pregnant members that we are unable to reach or who are difficult to engage. We leverage our network of community-based organization partners, such as Families First and FQHCs like One World, and CHWs to make in-person contact as appropriate. These outreach strategies help us identify pregnant members early and assist them in seeking prenatal services. Our staff participates in workgroups established by the Nebraska Perinatal Quality Improvement Collaborative, March of Dimes, the Nebraska Prenatal Plan of Safe Care Core Team

Meeting, and the Maternal Infant Mortality Focus Collaboration to identify strategies to connect members to prenatal care.

Doula Programs. We address health disparities and improve birth outcomes by promoting doula services.

- **Local Doula Support.** We will partner with local doula groups and our national doula partners to provide pregnant members in high disparate health inequity ZIP codes in Nebraska with the option of a doula.
- **Virtual Doula Services.** Our Doula Program will offer the option of virtual visits to remove the barrier of transportation. Virtual doulas offer perinatal support and lactation consultation services through a mobile app.

We will launch in-person doula services in areas with the highest maternal health disparities— ZIP codes 68111, 68104, and 68107— and then expand into additional zip codes. Our initial program will engage 100 members starting on Fall 2022.

Virtual Group Prenatal Care. Delivered through our partnership with Pomelo Care, pregnant Nebraska Total Care members can receive virtual group prenatal care grounded in the evidence-based Centering Pregnancy model. Group prenatal care has been proven to reduce preterm births by 30%. With just two accredited Centering Pregnancy sites in Lincoln and Omaha[5], ***Pomelo's virtual model increases member access to this verified approach to reducing preventable NICU stays.***

Implementing Required Health Screenings

Nebraska Total Care uses enrollment data, the 599 CHIP report, the HRS, the NOP or ONAF, and claims analysis to identify pregnant members daily. We routinely screen for pregnancy as part of our HRS process. Our Care Management team works with members who report pregnancy during HRS outreach to assist with NOP completion in the same call. This connects members to the correct services and initiates enrollment into our Start Smart program. Our NOP includes questions that screen members for alcohol, tobacco, and other substance use as well as SDOH needs. We allow members to complete our NOP form online, in-person, by phone, or by mail. We educate them on the NOP form in our Member Handbook, Provider Handbook, and website. Member Connect Self-Service Stations in FQHCs, CMHCs, and homeless shelters enable members to complete the HRS and NOP on self-service tablets.

Member Incentives. We incentivize members to complete the NOP through our My Health Pays program, which includes a reward of $15 for completion within the 1st and $10 within the 2nd trimesters. ***We have seen a 20.3% increase in our NOP completion rate from 2018 to 2021***. Beginning in 2023, members who submit the NOP can choose a car seat, portable crib, stroller, or meal delivery service (14 meals during pregnancy or pos-partum).

Provider Incentives. Our Provider Incentive program offers incentives based on timely NOP submission, rewarding more for first-trimester completion, enabling earlier outreach. We provide incentives for Obstetrical Needs Assessment Form (ONAF) completion. To encourage early screening, Nebraska Total Care offers tiered incentives for timely and complete submission of the ONAF, with the highest financial incentive for form completion in the first trimester. ***As a result of earlier notification, increased engagement with pregnant members led to a 14% decrease in NICU stays from 2020 to 2022.***

Start Smart Outcomes

Participants in Start Smart are:

- 7.9% less likely to have a baby born at low birth weight
- 20% less likely to have a baby born at very low birth weight
- 31.2% less likely to have a baby born at extremely low birth weight

Providing Follow-Up Support. Once the member is engaged, we assist them in completing an assessment and a plan of care and provide regular contacts based on the member's needs and preferences. Our Start Smart Care Coordination team reviews the NOP and HRS and conducts a comprehensive pregnancy assessment to identify SDOH needs and high-risk pregnancy factors. The team coordinates access to services and resources and assists members using our Provider Directory to identify perinatal and maternal fetal medicine specialists. Our CHWs provide perinatal coaching to encourage connection to prenatal care and screening completion while licensed BH clinicians support pregnant members with BH needs. ***Our engagement is effective - we have had a 45% increase in the rate of members successfully enrolled into Care Management within 30 days of NOP completion, from 2018 to 2021.*** The following member story illustrates how we ensure members are connected to prenatal care as early as possible.

Ensuring "Holly" has Access to Prenatal Support. Holly, a pregnant member with a history of 10 pregnancies with 5 full-term deliveries and 4 miscarriages was receiving support through our Start Smart for Your Baby program. Using motivational interviewing, our Care Manager (CM) learned that Holly had stopped taking medications for her anxiety and depression and had limited social support as her husband was frequently incarcerated. Our CM helped Holly apply for Aid to Dependent Children, ensured Holly had access to prenatal care and worked with Holly and her OBGYN to resume her behavioral health medications. Our CM supported Holly throughout her pregnancy and helped her prepare for the baby's arrival by helping her obtain baby items such as a Pack-N-Play, car seat, and other needed items. As a result of our CM's ongoing support, Holly delivered a healthy, full-term baby.

[5] "Centering Sites in Nebraska (NE)." Centering Sites for NE, https://centeringhealthcare.secure.force.com/WebPortal/ListOfCenteringSites?stateName=NE.

RFP 112209 O3

Attachment B.52
HRA Template

Complex Care Management Assessment - Adult V2

Start Date:
Complete Date:
Case#:
Score: NA

Provider Name:
Provider Specialty:
Case Name:

MEMBER INFORMATION

NOTE: MANY OF THE QUESTIONS IN THIS ASSESSMENT MAY BE PRE-POPULATED FROM THE MOST RECENT RESPONSES GIVEN IN ANOTHER ENTERPRISE ASSESSMENT. PLEASE REVIEW AND UPDATE, AS NEEDED.

What is your preferred name?

Race

Are you Native American?

Ethnicity

Preferred Language

What is the highest level of education you have completed?

What is your marital status?

What is your gender identity?

What is your sexual orientation?

Do you have any religious or spiritual beliefs that impact your health care?

Please explain religious or spiritual beliefs that impact your health care.

Do you ever have difficulty understanding what your doctor or health care provider explains to you about an illness, medical condition, and/or treatment?

How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy, or when you need to fill out medical forms?

Do you have any problems with your hearing, vision, or speech requiring special services?

Please explain problems with hearing, vision, or speech.

HEALTH STATUS

In the past 12 months, has your overall health stayed about the same, improved, or worsened?

On a scale from 0-10, how ready are you to make changes for your health?

What changes are you ready to make for your health?

Do you have a doctor or health care provider?

***It is important to identify a doctor or health care provider to help you stay healthy and in case you get sick.**
Have you ever been told by a doctor or health care provider that you have any of these conditions? (check all that apply)

Arthritis

Asthma as an Adult

Cancer

Chronic Kidney Disease

COPD/Emphysema

Diabetes, Type 1

Diabetes, Type 2

Pre-diabetes

Heart Disease

Heart Failure

Hepatitis

High blood pressure

High cholesterol

HIV

Learning Disability

Sickle Cell Disease (not trait)

Stroke

Transplant

Do you have any other conditions not listed above?

Please include details about all diagnoses above, including dates of onset. If member has none of the above, please type N/A.

Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease?

Please list condition(s) you have.

Have you ever had any serious injuries to your head or neck in your lifetime?

ACTION: If member had any serious injuries to head or neck, complete TBI Identification questions.
Do you have a personal history of substance misuse?

What type of personal misuse?

Alcohol

Illegal drugs

Prescription drugs

Have you received treatment for alcohol or substance misuse in the last 6 months?

Have you been diagnosed with a behavioral health disorder like anxiety, depression, bipolar or schizophrenia?

Please list the behavioral health disorder(s) you have.

Have you been to the ER or hospitalized in the last 3 months due to a behavioral health condition?

Are you actively receiving treatment for a behavioral health disorder?

Please list details about all previous ER or hospitalizations due to a behavioral health condition. If none, type N/A.

How many times have you been in the hospital in the last 3 months?

Please list details about all previous hospitalizations. If none, type N/A.

How many times have you been in the Emergency Department in the last 3 months?

Please list details about recent ED use. If none, type N/A.

Have you had any surgeries? (Check all that apply and enter date and details.)

Adrenal Gland Surgery

Appendectomy

Bariatric Surgery

Bladder Surgery

Breast Surgery

Cesarean Section

Cholecystectomy

Colon Surgery

Coronary Artery Bypass Graft

Esophagus Surgery

Gastric Bypass Surgery

Hemorrhoid Surgery

Hernia Repair

Hysterectomy

Kidney Surgery

Neck Surgery

Prostate Surgery

Small Intestine Surgery

Spine Surgery

Stomach Surgery

Thyroid Surgery

Other Surgery

Please list any other previous significant past illnesses, surgeries, or procedures not already noted.

Have you and your healthcare provider discussed elective surgery for any current condition(s)?

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

Does anything prevent you from taking your medicines the way your doctor or health care provider wants you to?

Do you ever forget to take your medicines?

Please list all current and past medications. (Include schedules and dosages ONLY for current medications.) Document here and/or in the Medication Module. Complete medication reviews if needed. If none, type N/A.

On a scale of 0-10, where 0 = Health problems had no effect and 10 = Health problems had an effect, how much did your health problems affect your ability to do your regular daily activities (other than work at a job) during the past 7 days?

BEHAVIORAL HEALTH SCREENING

In general, how satisfied are you with your life?

Please explain why you are very dissatisfied.

Is there anything you would like to learn, change, or achieve to live your life the way you want?

During the past month, have you often been bothered by feeling lonely?

ACTION: If member answered "Yes" to "feeling lonely" question, complete Three Item Loneliness Scale questions.
During the past month, have you often been bothered by feeling down, depressed, or hopeless?

During the past month, have you often been bothered by little interest or pleasure in doing things?

ACTION: If member answered "Yes" to "feeling down" and/or "little interest" questions, complete PHQ-9 questions for members under age 65 or complete GDS questions for members age 65 and older.
Do you feel that stress in your life is affecting your health?

What are your plans for managing stress?

ACTION: If member answered "Yes" to "stress affecting their health", complete GAD-2 questions.

During the past year, how often did you have 5 or more alcoholic drinks in one day?

During the past year, how often did you use tobacco products?

During the past year, how often did you use prescription drugs for non-medical reasons?

During the past year, how often did you use illegal drugs?

ACTION: If member reports any prescription misuse or illegal drug use in the last year, complete NIDA Modified Assist questions.
How many hours of sleep do you usually get a night?

Do you often have trouble falling or staying asleep, or sleeping too much?

PAIN

During the last month, have you had pain that interfered with completion of housework or your ability to work outside the home?

What type of pain have you been experiencing?

How would you rate your pain on a 0-10 scale at the PRESENT time, that is right now, where 0 is 'no pain' and 10 is 'pain as bad as could be'?
In the past 6 months, how intense was your WORST pain rated on a 0-10 scale where 0 is 'no pain' and 10 is 'pain as bad as could be'?
In the past 6 months, on the AVERAGE, how intense was your pain rated on a 0-10 scale where 0 is 'no pain' and 10 is 'pain as bad as could be'? (That is, your usual pain at times you were experiencing pain.)
ACTION: Average the 3 question scores above. Is the average score 5 or greater?

About how many days in the last 6 months have you been kept from your usual activities (work, school or housework) because of pain?
In the past 6 months, how much has pain interfered with your daily activities rated on a 0-10 scale where 0 is 'no interference' and 10 is 'unable to carry on any activities'?
In the past 6 months, how much has pain changed your ability to take part in recreational, social and family activities where 0 is 'no change' and 10 is 'extreme change'?
In the past 6 months, how much has pain changed your ability to work (including housework) where 0 is 'no change' and 10 is 'extreme change'?
ACTION: Average the 3 question scores above. Is the average score 5 or greater?

ACTIVITIES OF DAILY LIVING

Do you need help with any of the following daily activities: Walking, getting out of a chair, eating, bathing, dressing, or going to the bathroom?

Are you able to safely walk once in a standing position on a variety of surfaces?

Are you able to get into and out of bed or a chair by yourself?

Are you able to eat meals and snacks by mouth without help?

Are you able to take a bath or shower by yourself?

Are you able to dress yourself independently?

Are you able to get to and from the toilet or bedside commode?

Do you have complete self control of your bowel and bladder functions?

Who helps you with these activities now?

Could you use additional help with these activities?

Do you currently have any open wounds? (ex: bed sore, accident wound, etc.)

List onset and origin of open wounds.

Do you have supplies to care for your wound(s)?

Is your wound healing without any complications?

Do you use any assistive devices?

What assistive devices do you use? (check all that apply)

Cane

Walker/Crutches

Wheelchair

Scooter/Power Wheelchair

Hospital Bed

Hoyer Lift

Oxygen

Other

Do you receive any home health services?

What services do you currently receive in your home? (check all that apply)

Home Health

Homemaking

Home Delivered Meals

Hospice

Personal Care

Other

Have you fallen in the last year?

How many times have you fallen?

PREVENTATIVE CARE

When was the last time you saw a dentist?

***Lack of routine dental care can lead to gum disease. Gum disease has been linked to preterm babies, stroke, and uncontrolled diabetes. Routine dental care is important for your oral and physical health.**
What is your height (enter in feet/inches)?

in Feet

in inches

What is your weight (enter response in pounds)?

Have you or a health care provider been concerned about your weight?

Do you eat a healthy diet, such as eating fruits, vegetables and whole grains every day and limiting your sugar and saturated fats?

Do you eat at least 2 meals per day?

Do you have problems with your teeth or mouth that make it hard for you to eat?

Do you participate in regular physical activity?

***Regular physical activity helps improve your overall health and fitness, and reduces your risk for many chronic diseases. It is recommended to get at least 150 minutes of moderate exercise and 2 days of muscle strengthening in each week.**
Have you received a flu shot in the last 12 months?

***Flu shots are recommended for everyone over 6 months of age every year. Getting an annual flu shot is the best way to protect yourself and your family from the flu.**
Do you always use a seatbelt when you drive or ride in a car?

***Seat belt use is one of the most effective ways to save lives and reduce injuries in crashes.**

Are you female or male?

If you are sexually active now or have been in the past, have you had a test for STI's like Chlamydia within the last year?
Are you pregnant?

ACTION: For women of childbearing age, consider reproductive life planning questions from the SSFB Interconception questions.

SOCIAL DETERMINANTS OF HEALTH

Do you have a paid or volunteer job in the community?

Do you currently have concerns about having enough money to pay for your basic needs?

Within the past 12 months, did you worry that your food would run out before you got money to buy more?

Within the past 12 months, did the food you bought just not last and you didn't have money to get more?

In the past 2 months have you been living in stable housing that you own, rent or stay in as part of a household?*

Which of the following best describes your current living situation? (Select ONE only)

Do you have any concerns about your home's environment? Are there any hazards that concern you? (examples include: no heat, no water, unsafe staircase, etc.)

Please explain concerns about your home's environment.

Do you always feel safe in your home and around all the people in your life?

Please explain any safety concerns you have.

Do you have access to a safe, reliable telephone?

Do you ever have any problems with transportation to your medical appointments?

Do you have a primary caregiver who helps you on a regular basis?

Does your caregiver adequately support your health care needs?

What resources (caregiver/community support/paid support) are you currently receiving?

If member has a caregiver, does their caregiver need any additional training or support services?

Are you the primary caregiver for someone in your life?

Do you feel that most of the time you are able to handle the demands of being a caregiver?

LIFE PLANNING

Do you have an Advanced Directive or a Living Will?

Do you have a Health Care Representative and/or Health Care Power of Attorney?

Do you have Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms?

Has the Advance Directive, Living Will, MOLST or POLST form been shared with the PCP, treating provider(s) and caregiver(s)?

Are you interested in participating in care team meetings to discuss your health care needs?

Who would you like to participate with you and/or for you?

PCP

Specialist

Home Health

Therapist

Pharmacist

Caregiver

Authorized Representative

Clergy

Family Member/Neighbor

Other

CARE MANAGEMENT CONCLUSIONS

Did member report poor health status on HRA, HRS, or other assessment?

Please explain reason for poor health rating.

Please summarize the event or diagnosis that led to identification of this member for complex care management.

Please summarize your conclusions about the member's physical health status including presence/absence of comorbidities and their current status, compliance with medications, and CM next steps.

In your clinical opinion, would you be surprised if the member expired within the next 12 months?

ACTION: Follow health plan process for palliative care evaluation and referral, if member is interested.
Please summarize your conclusions about the member's behavioral health status including cognitive functions, mental health, compliance with medications, substance use disorders and CM next steps.

Please summarize your conclusions about the member's hearing, vision and/or speech needs and their impact on effective communication, care or acceptability of specific treatments and CM next steps.

Please summarize your conclusions about the member's cultural and linguistic needs and their impact on effective communication, care or acceptability of specific treatments and CM next steps.

Please summarize your conclusions about the member's functional status (ADL needs) and CM next steps

Please summarize your conclusions about the member's economic and social conditions and CM next steps.

Please summarize your conclusions about the member's adequacy of caregiver resources and family involvement and CM next steps.

Please summarize your conclusions about member's life planning activities and CM next steps.

Please summarize your conclusions about the adequacy of the member's health benefits and whether they are sufficient to fulfill the treatment plan and CM next steps.

Please summarize your conclusions about the member's eligibility and access to the following community resources and CM next steps.

Which community resources will you be referring the member to?

Community Mental Health

Transportation

Wellness Organizations

Palliative Care Programs

Other

Which agencies/services will you be referring the member to?

Behavioral Health Provider

PCP

Specialist

In-home Visiting Providers

Disease Management

Telemedicine

Waiver Program

WIC

Please list any additional referrals completed.

INTERNAL CARE MANAGEMENT

Assessment Completed Date

Assessment Completed By (Name)

Credentials of staff completing assessment?

Name of health plan, vendor, or delegated entity completing assessment?

By what method was the information obtained?

Was assistive (TDD/TYY) equipment used to complete this assessment?

Was a translator used to complete this assessment?

Translator information

Was information obtained from a member's representative/caregiver/POA?

ATTESTATION: I have reviewed the Documentation Module. The member's POA and/or Authorized Representative information is updated in the Document Summary section.

ATTESTATION: I have reviewed the Member Demographics module. The member's General Information section and Contact Information section have been transcribed and updated with the information obtained in this assessment.

ATTESTATION: I have reviewed and updated the Member Contact Summary with caregiver/POA information if applicable.

ATTESTATION: I have reviewed the Provider Contacts Summary module and the information is up to date and accurate.

ATTESTATION: I have reviewed the Member's Diagnosis module and the member's information is up to date and accurate.

ATTESTATION: I have reviewed all of the Member's Care Alerts.

OSU TBI Identification

I am going to ask you about injuries to your head or neck that you may have had anytime in your lifetime.
In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
In your lifetime, have you ever injured your head or neck in a fall or from being hit by something?
Have you ever injured your head or neck playing sports or on the playground?
(for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)

In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
Interviewer Instruction: Ask the following questions if any of the previous questions were answered YES.
If more injuries with LOC, how many?

Longest knocked out?

How many over 30 minutes?

Youngest age when the LOC occurred?

Interviewer Instruction: Ask the following questions if all previous questions were answered NO.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?
INTERPRETING FINDINGS

A person may be more likely to have ongoing problems, if they have any of the following:

WORST - One moderate or severe TBI

FIRST - TBI with loss of consciousness before age 15

MULTIPLE - 2 or more TBIs close together, including a period of time when they experienced multiple blows to the head
RECENT - A mild TBI in the last weeks or a more severe TBI in the last months

OTHER SOURCES - Any TBI combined with another way their brain function has been impaired

Three-Item Loneliness Scale

How often do you feel that you lack companionship?

How often do you feel left out?

How often do you feel isolated from others?

Is the total score 6 or above?

PHQ-9

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Trouble falling or staying asleep, or sleeping too much

Feeling tired or having little energy

Poor appetite or overeating

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

Trouble concentrating on things, such as reading the newspaper or watching television

Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.
Thoughts that you would be better off dead, or of hurting yourself

Total Score/Depression Severity

Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

Are you basically satisfied with life?

Have you dropped many of your activities and interests?

Do you feel that your life is empty?

Do you often get bored?

Are you in good spirits most of the time?

Are you afraid that something bad is going to happen to you?

Do you feel happy most of the time?

Do you often feel helpless?

Do you prefer to stay at home, rather than going out and doing new things?

Do you feel you have more problems with memory than most?

Do you think it is wonderful to be alive now?

Do you feel pretty worthless the way you are now?

Do you feel full of energy?

Do you feel that your situation is hopeless?

Do you think that most people are better off than you are?

Total Score/Depression Severity

Is the total score >5 and <10?

Is the total score >or =10?

GAD-2

Over the last two weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge.

Not being able to stop or control worrying

Total Score/Anxiety Severity

NIDA-Modified Assist V2.0

In your LIFETIME, which of the following substances have you ever used?

Cannabis (marijuana, pot, grass, hash, etc.)?

Cocaine (coke, crack, etc.)?

Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?

Methamphetamine (speed, crystal meth, ice, etc.)?

Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?

Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)?

Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?

Street opioids (heroin, opium, etc.)?

Prescription opioids (fentanyl, oxycodone (OxyContin, Percocet), hydrocodone (Vicodin), methadone, buprenorphine, etc.) for Non-Medical Use?
***** Please record NON-MEDICAL USE ONLY: Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.**
Other drugs?

Have you ever used any drug (including steroids) by injection for Non-Medical Use?

NOTE: The patient should not indicate "No" for all of the above drugs since they indicated they used an illegal or prescription drug for non-medical reasons in the past year.
Total Score

SSFB Mini Interconception

***Thinking about your goals for having or not having children is called a reproductive life plan. Let's discuss some questions you may want to think about.**
Are you considering getting pregnant in the next year?

Program Enrollment

Enroll Member in Program now?

Member/guardian agrees to participate in program?

RFP 112209 O3

B. Technical Approach

V.M Quality Management

V.M Quality Management

64. Provide a description of the Bidder's proposed QAPI program. Include the following in the description:
- *The proposed structure, policies and procedures that explain the accountability of each organizational unit.*
- *The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable.*
- *Proposed QAPIC membership and committee responsibilities.*
- *How the Bidder will comply with and support MLTC's quality strategy.*
- *How focus areas will be selected, including how data will be used in the selection process.*
- *The proposed QAPI work plan, including planned initiatives.*

Page Limit: 10 (Per Addendum 3, Q&A #33 the QAPI work plan can be provided as an attachment)

Commitment to Quality

As a quality-driven organization, we focus on pursuing the Quadruple Aim of improved member and provider experience, health outcomes, and cost efficiencies. We promote this by facilitating access to affordable, integrated, high-quality, and equitable care through a quality program built on local knowledge and decades of experience serving Medicaid and CHIP beneficiaries across the country. With over five years of experience operating in the Nebraska Medicaid and CHIP programs, we:

- Achieved a four-star health plan rating from NCQA Health Plan Accreditation in the first year of reporting for the measurement year 2020
- Achieved a five-star rating on Adult CAHPS scores on the first submission
- Ranked #1 in Nebraska Medicaid provider satisfaction for three consecutive years (2019 to 2021)
- Have seen a steady decrease in ED utilization since 2017, with an overall 27% decrease from 2017 to 2021
- Have paid out close to $400,000 in incentive payments from 2019 to 2021 in support of providers in improving quality, access, and outcomes

Our Quality Assessment and Performance Improvement (QAPI) Program is led by a team of local subject matter experts with the training and qualifications to best serve the Heritage Health population, as further described in this response. All our work is done through collaborative partnerships with our providers and other organizations to improve the quality of care (QOC) and outcomes. We view our health plan responsibilities through a health equity lens and integrate qualitative and quantitative data to identify and address disparities and promote equal access to services. Our formal QAPI goals align with MLTC goals, as highlighted in this section, and detailed throughout our response.

Through quality campaigns, targeted interventions, initiatives such as IHI's Ask Me 3, value-based care, and provider collaboration, we continue to see year over year improvement in publicly reported HEDIS ratings. Statistical modeling is applied to specific measures where there are significant shifts in the denominator to determine if improvement was "significant" or "expected" based on the magnitude of the shift. This includes significant increases in performance between 2018 and 2020 measurement years (MY), such as:

Measure	Measure Description	% Rate Improvement
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis	33.42*
ADD-m	Continuation & Maintenance follow up after initiation of ADHD medications	7.03
CBP	Controlling High Blood Pressure	6.33**
CCS	Cervical Cancer Screening	5.5**
CIS 10	Childhood Immunization Status: Combo 10	11.93**
PPC-pp	Prenatal and Postpartum Care: Postpartum Care	11.21**
SMC	Cardiovascular Monitoring for People with Schizophrenia	42.16*
SMD	Diabetes Monitoring for People with Schizophrenia	9.46*
SPC-a	Statin Therapy for patients with cardiovascular disease – 80% adherence	10.44*
SPD-a	Statin Therapy 80% adherence for patients with diabetes	9.06*
W15	Well-child visits in first 15 months of life – 6 or > visits	11.89
WCC-BMI	Weight Assessment for Children/Adolescents –BMI Total	7.46**
WCC-cp	Weight Assessment for Children/Adolescents –Counseling Physical Activity	16.93**

*Statistically significant, **Hybrid measure (significant)

QAPI Program Purpose and Scope. Nebraska Total Care's mission is to transform the health of the community, one person at a time. The purpose of the QAPI Program is to provide the infrastructure and activities necessary to support our mission through improved clinical care quality delivered in a safe and appropriate setting. Improving care requires both member and system-level engagement, as illustrated in **Figure 64.A** equally drives our quality priorities.

Figure 64.A Our QAPI Program is mission driven.

Our QAPI scope includes, but is not limited to, assessment of access to care, barriers to care, QOC, Care Management, integration of care and services, and continuity. Areas subject to quality oversight include:

- Member safety
- Provider credentialing and recredentialing
- Vendor oversight
- Adoption and compliance with preventive health and clinical practice guidelines
- Acute and chronic Care Management
- Vision and dental health care
- Pharmacy benefit utilization and oversight
- Under- and over-utilization
- Continuity and coordination of care
- Appointment availability/network access
- Member and provider experience
- Complaints, grievances, and appeals
- Departmental performance and service
- Cultural humility
- Confidentiality
- Medical BH, LTSS, pharmacy, and SDOH integration
- Medicaid/Medicare integration
- Member Rights and responsibilities

Nebraska Total Care is NCQA Health Plan Accredited, and we are actively pursuing Health Equity Accreditation through NCQA, anticipated in October 2022. Central to our approach, our QM processes are directly aligned with NCQA and MLTC standards to guide innovative strategies founded on several core components and resources:

- A culture of continuous quality improvement (CQI) embraced across the organization and woven into day-to-day operations and business practices
- Direct alignment with the MLTC quality strategy and all state and Federal requirements, including 2 CRF §438.330
- A detailed annual QAPI Program Description, Work Plan, and Evaluation
- Incorporation of national evidence-based practices, including those developed by professional societies such as the American Academy of Pediatrics, American College of OB/GYN, American Diabetes Association, American Dental Association, American Psychiatric Association, and the American Society of Addiction Medicine (ASAM)
- Integration of innovations in care delivery and technology identified and created by our Centene affiliates and corporate partners
- Quantitative and qualitative data collection with data-driven decision-making using our Centelligence reporting and

analytics platform to identify and understand member and community needs and facilitate our use of data by collecting, integrating, storing, analyzing, and reporting data from all sources
- Performance Improvement Projects (PIPs) to improve outcomes for targeted member populations
- Value-based Purchasing (VBP) and provider analytics tools, including actionable data to close care gaps and improve health outcomes to support quality across the delivery system
- Collaboration with providers to promote integrated physical and behavioral health (BH) care, including integrated quality committees and programs, and integration of services for dual eligible members
- Partnerships that leverage the strength of community-based organizations (CBOs) to engage members and deliver effective interventions and address Social Determinants of Health (SDOH)
- Innovative strategies used to engage members in comprehensive programming, including health literacy, prevention, and condition management
- Feedback provided by and engagement with members, families, caregivers, and providers in the design, planning, and implementation of CQI activities
- Evaluation of member and provider experience and grievances and appeals data
- The proposed structure, policies and procedures that explain the accountability of each organizational unit

Meeting and Exceeding the Scope of Work (SOW). Nebraska Total Care is currently in compliance with all existing SOW requirements and will meet or exceed all new requirements described in Section V.M of the RFP. Below we describe our overall approach for QM in alignment with the MLTC quality strategy and per the RFP.

Ensuring Accountability for Quality Across the Organization

Our QAPI Program includes shared accountability for quality outcomes across clinical, network, and operational areas. We identify priorities; establish clear aims, goals, and objectives; and utilize reliable and valid methods of ongoing monitoring, analysis, evaluation, and improvement. Through this systematic approach, we improve member outcomes and experience, improve health equity and access to care, enhance provider experience, and meet MLTC goals and objectives. ***Integrating CQI as a core business strategy for the entire health plan, we encourage all Nebraska Total Care staff to continuously ask, "How are we doing?" and "Can we do it better?".*** The QAPI Program relies on participation, collaboration, and representation from across the organization to help meet reporting requirements, develop core documents, support initiatives, conduct analysis, and monitor outcomes, including but not limited to Operations, Population Health Management, BH, Contracting and Provider Network Management, Pharmacy, Quality, Appeals and Grievances, Member Services, Marketing and Communications, Community Engagement, Delegation/Vendor Oversight, and Compliance. The cross-departmental staff has performance goals related to organizational quality and objectives as part of their individual performance management plans.

Alignment with MLTC

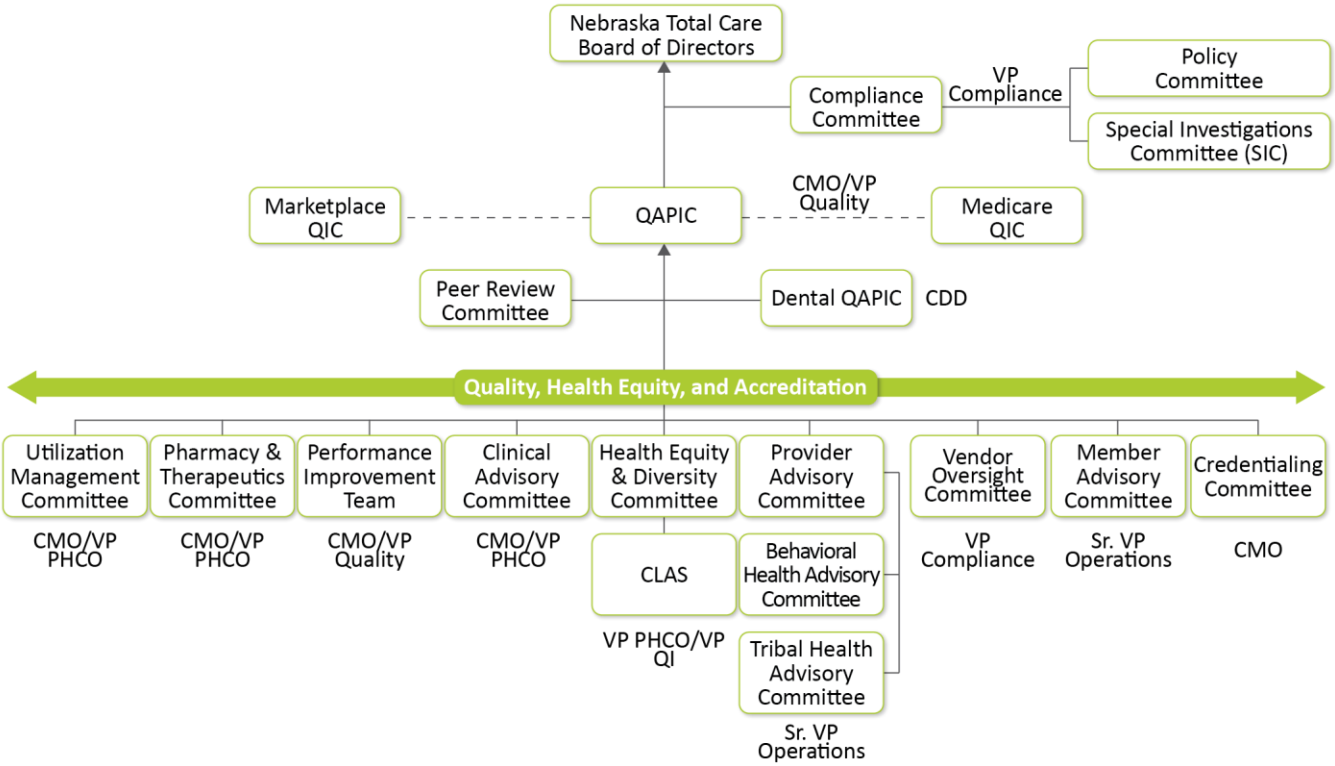
Nebraska Total Care aligns the delivery system by mirroring State QPP Performance Measures in our value-based purchasing arrangements, driving alignment toward the same quality goals.

Our executive and management teams apply data-driven decision-making in strategic planning and daily operations. In turn, each functional area has defined service metrics. Supported by QM staff and leadership, functional area leaders and cross-departmental staff engage in structured workgroups and quality meetings to review data metrics (e.g., appeals, grievances, QOC, HEDIS, CAHPS, contract compliance, and provider and member experience survey results) for trends or variances. To assess the entire Nebraska Total Care impact as a collaborative versus isolated unit, staff determine root causes and barriers; recommend, develop, and implement strategies; evaluate improvement and assess next steps. The process includes facilitating stakeholder input from providers, members, community-based organizations (CBOs), and staff, as appropriate. Engaging the listed departments, we currently have three cross-functional HEDIS workgroups (Adult Chronic Conditions, Prevention/Screenings, BH). With the implementation of these teams, we have seen a direct improvement in HEDIS focus areas, including, for example, a 6.33% increase in controlling blood pressure.

Quality Trainings. Clinical QM staff go through a four-week training upon hire with additional annual and ad hoc trainings based on opportunities for improvement and MLTC or other program updates. To ensure our work is delivered through a health equity and trauma-informed lens, staff are trained in topics including Cultural Competency, including Tribal Sovereignty 101 designed with direct contributions from Tribal members; Person-Centered Thinking; Poverty Simulation; Communication Skills; Motivational Interviewing; SDOH; Trauma-Informed Care Lifespan; and Trust-Based Relationship Empathetic Listening and Exhaustion. Additionally, key leaders across the organization are trained on QAPI methodologies and topics such as NCQA, HEDIS measurement, Plan-Do-Study-Act, and CQI. We also encourage staff and leadership training and certification in QI methodologies and best practices, such as Certified Professional in Healthcare Quality (CPHQ), Institute for Healthcare Improvement (IHI) certification in Quality and Safety, Project Management Profession certification, Lean, and Six Sigma.

Board of Directors (BOD). The Nebraska Total Care BOD is the governing body designated for overseeing the development, implementation, and evaluation of the QAPI Program and holds ultimate authority and accountability for the QOC and services provided to all Nebraska Total Care members. The BOD has delegated the operating authority of the QAPI program to the QAPIC and has established a comprehensive committee structure to ensure all aspects of the QAPI program are adequately monitored. Members of the BOD are included in our response to Question V.C.9.

Quality Committee Structure. The Nebraska Total Care quality program committee structure is comprised of the Quality Assurance and Performance Improvement Committee (QAPIC) which has oversight over twelve cross-functional subcommittees. Nebraska Total Care's strong quality committee structure includes staff, members, and providers who are actively participating in the Medicaid program. The committee structure provides a two-way information flow from the sub-committees through the QAPIC and back, as appropriate. As described in detail in the QAPIC subsection below, the QAPIC is the senior management-led quality committee accountable directly to the BOD. The QAPIC meets at least quarterly and is responsible for the oversight of the QAPI Program, policies, and procedures. To ensure health equity across all committees a representative from the Health Equity and Diversity Committee (HEDC) participates in all quality subcommittees. The following graphic provides an overview of our committee structure to promote coordination, collaboration, integration, and quality across the organization.



Schedule of QM Activities. The QAPI Program incorporates an ongoing documentation and feedback cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation, and evaluation. Several key documents demonstrate Nebraska Total Care's CQI cycle using a pre-determined documentation flow, all of which will be submitted to MLTC for review and approval at least ninety calendar days before implementation and annually thereafter. These Trilogy documents form the framework for our QAPI Program and consist of the Program Description, Work Plan, and Annual Evaluation. On an annual basis, documents are developed, reviewed, and approved by QAPIC, and approved and signed off by the BOD, with the opportunity for mid-term evaluation and course correction as appropriate.

QAPI Program Description. Nebraska Total Care's QAPI Program Description outlines the structure and processes used to monitor and improve the quality and safety of clinical care, integration with non-clinical services, and the quality of services. The Program Description includes the following: specific roles, structure, and function of the QAPIC and other committees; accountability to the BOD; a description of staff and technical resources that are devoted to the QAPI; mechanisms to ensure integration across services; and member safety.

QAPI Work Plan. To implement the comprehensive scope of the QAPI Program, the QAPI Work Plan incorporates the

strategic direction provided by the BOD and MLTC, and clearly defines the activities that must be completed by each department and all supporting committees throughout the measurement year. The Work Plan specifies the activities, the committee(s) responsible for the activity, the date of expected task completion, and the monitoring techniques that will be used to ensure completion within the established timeframe. In addition to annual development and approval, the Work Plan is reviewed by the QAPIC at regular intervals throughout the year to monitor progress and intervene or update as appropriate.

QAPI Annual Evaluation. The QAPI Program Evaluation includes a summary of all QM activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The evaluation of the impact and effectiveness of the QAPI is used in developing the QAPI Program Description and Work Plan for the subsequent year. Nebraska Total Care's Chief Medical Officer (CMO) and QM Coordinator are responsible for coordinating the evaluation process through the QAPIC and BOD for approval annually.

Dental Quality Infrastructure. With Envolve, Nebraska Total Care has the benefit of an experienced dental partner as we integrate dental services into our programs and benefits. We will establish a separate Dental QAPI Program and committee structure as described in Section M.8 of the SOW, these functions will report up through our overall quality structure to ensure appropriate alignment, integration, and coordination. To further assist in promoting the importance of dental health on a person's whole health, we are actively recruiting dental providers to serve on our Nebraska Total Care BOD, QAPIC, and other quality committees.

In partnership with Envolve, we will establish and implement a Dental QAPI program per 42 CFR § 438.330, including a Dental QAPI Program Description, Work Plan, and Annual Evaluation. The overall scope and goals of the Nebraska Total Care Dental QAPI are similar to that of our Nebraska Total Care QAPI, with a focus on access to and quality of dental services. For example, we will review all aspects of dental care, including accessibility, availability, timeliness, and clinical appropriateness of care and services provided through our dental network. We will also evaluate all aspects of internal administrative dental processes related to service and QOC, including credentialing, QM, network management, regulatory compliance, UM, complaints, grievances and appeals, and member and provider services. A formal evaluation of the Dental QAPI Program will be performed annually and include:

- Measuring, monitoring, trending, and analyzing the quality of dental care delivery against performance goals and/or recognized benchmarks, stratifying by population to uncover any health disparities
- Fostering continuous quality improvement in the delivery of member care by identifying aberrant practice patterns and opportunities for improvement in dental care and the prevention of dental health diseases
- Evaluating the effectiveness of implemented changes to the Dental QAPI Program
- Integrating dental care into whole health care strategies
- Reducing or minimizing the opportunity for adverse impact on members
- Improving efficiency, cost-effectiveness, value, and productivity in the delivery of dental services
- Evaluating the delivery of appropriate dental care according to professionally recognized standards
- Evaluation of written policies and procedures to ensure that quality, accessible dental care is provided to the members, including preventive care
- Evaluating practitioner accessibility and availability (inclusive of time, distance, appointment availability, and disability access)
- Measuring, monitoring, trending, and analyzing member grievances and provider complaints
- Monitoring member safety
- Performance Improvement Projects
- Credentialing and recredentialing

Quality Program Infrastructure

Nebraska Total Care maintains enough highly trained and qualified staff to meet or exceed all QAPI requirements on time, including MLTC reporting requirements, PIPs, satisfaction surveys, and external quality review activities. Our QAPI Program is separate and distinct from Utilization Management, Care Management, and other clinical and operational units with processes and systems in place to ensure appropriate coordination, collaboration, and integration, as described above.

Chief Medical Officer/Medical Director (CMO). Nebraska Total Care's CMO, Dr. Chris Elliott is located in Nebraska and has an active unencumbered Nebraska license, per State laws and regulations, to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the QAPI Program, the Utilization Management Program, and the grievance system. This includes developing, implementing, and interpreting medical policies and procedures; service authorization and claim reviews; referral management, discharge planning, and credentialing activities; and medical review of grievances and appeals. The CMO also participates in Quality meetings with MLTC and

other system partners as requested by MLTC, and leads the UM, QAPI, Credentialing, Clinical Advisory, and Provider Advisory Committees.

Behavioral Health Medical/Clinical Director (BHMD). The BHMD, Dr. Wendy Welch is a Nebraska-licensed psychiatrist responsible for monitoring and directing BH quality activities through the subcommittees reporting to the QAPIC. Dr. Wendy Welch is triple-boarded by the American Board of Psychiatry, Child and Adolescent Psychiatry, and Addiction Psychiatry. The BHMD closely collaborates with the CMO and other Quality staff and provides oversight of the BH aspects of care to ensure the appropriateness of care delivery, integration of physical and BH services, and quality of service.

Dental Director. We are actively recruiting a Dental Director who will be a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree with five years of clinical dental practice experience, including three years of experience in a government-sponsored health care setting. The Dental Director will lead and coordinate dental activities and oversee the application of appropriate clinical knowledge in authorization decisions. The Dental Director will be responsible for developing, implementing, and interpreting dental policies and procedures; participating in tracking and trending quality-of-care issues related to dental services; and leading the Dental QAPIC. They will be supported in quality initiatives by our Dental Management Coordinator, Dr. John Rich.

Quality Management Coordinator (QM Coordinator). The QM Coordinator, Aimee Black is located in Nebraska as a Registered Nurse and Certified Professional in Healthcare Quality, with experience in QM, data analysis, barrier analysis, and project management as it relates to improving the clinical QOC and quality of service provided to members. The QM Coordinator reports to the CEO of the Health Plan and is responsible for directing the activities of Nebraska Total Care's QM staff in monitoring and auditing Nebraska Total Care's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The QM Coordinator assists the BOD and senior executive staff, both clinical and non-clinical, in overseeing the activities of Nebraska Total Care operations to meet Nebraska Total Care's QAPIC goals and coordinates QAPIC proceedings in conjunction with the CMO; support corporate initiatives through participation in committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

EPSDT and Maternal Child Health Manager. Susan Jeffrey, located in Nebraska is a Registered Nurse with QM leadership experience. The EPSDT and Maternal Child Health Manager have operational accountability for the QAPI Program under the QM Coordinator. She is also responsible for ensuring members and providers are aware of and obtaining the required EPSDT services and providing education as needed and overseeing activities related to improving the quality outcomes for our pregnant members and their newborns.

Performance and Quality Improvement Coordinator. Jeremiah Blake located in Nebraska is a Registered Nurse highly experienced in health care analytics and health informatics. He collaborates closely with cross-functional health plan staff and leaders to identify and deliver robust reporting and analytics capabilities to support data-driven decision-making and quality reporting, trending, and performance improvement.

Quality Improvement (QI) Coordinators. QI Coordinators located in Nebraska are highly trained clinicians with significant experience in a health care setting; experience with data analysis and/or project management. The QI Coordinators report to the EPSDT and Maternal Health Child Health Manager and focus on potential QOC case reviews, medical record audits, data collection for various QI studies and activities, and data analysis along with HEDIS, and implementation of improvement activities. The QI Coordinators may specialize in one area of the quality process or may be cross-trained across several areas. The QI Coordinators collaborate with other departments as needed to implement corrective action or improvement initiatives as identified through our QAPI activities and QOC reviews.

HEDIS Project Manager (PM). The HEDIS PM is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS PM coordinates the documentation, collection, and reporting of HEDIS measures to both NCQA and State as required by the contract. The HEDIS PM is supported by the QI Coordinators and collaborates with other departments as needed to implement corrective action or improvement initiatives related to performance measures as identified through Nebraska Total Care's quality improvement activities and QOC reviews.

Quality Practice Advisors (QPAs). Highly trained and experienced staff with experience in HEDIS or quality improvement reviews, QPAs provide onsite support to our provider partners. QPAs educate providers and supports practice sites on HEDIS measures and appropriate medical record documentation and coding and assist in resolving concerns to meet State and Federal standards for HEDIS.

Accreditation Specialist. The Accreditation Specialist is a staff member with extensive experience in developing performance improvement and quality improvement measures tracking and outcomes reporting. The Accreditation Specialist is responsible for maintaining departmental documentation to support MLTC contract compliance requirements and NCQA standards compliance.

Senior Health Equity Specialist. The Senior Health Equity Specialist, Amy Wing, located in Nebraska, is a Registered Nurse with significant related experience. She is responsible for maintaining compliance with regulations and contractual obligations of Culturally and Linguistically Appropriate Services (CLAS) and Health Equity and ensuring that culturally and linguistically appropriate services are provided to members, including identifying and implementing health equity initiatives and assessing operations for gaps. The Senior Health Equity Specialist leverages feedback from providers, members, vendors, and CBOs in the development of strategy and implementation and makes recommendations for CLAS and Health Equity efforts as aligned with contractual, accreditation, and quality improvement opportunities to senior management.

Coordination with Corporate Entity. Nebraska Total Care's QM Department is incorporated into the overarching structure of our national corporate partner, Centene Corporation. Centene Corporate divisions and Subject Matter Experts support local operations to provide guidance and oversight and share best practices with affiliate plans while Nebraska Total Care maintains local decision-making and control. We serve on local, state, and national committees with corporate and affiliate partners, sharing knowledge, best practices, lessons learned, expertise, and guidance. Internal collaboration from the corporate structures and affiliate organizations promotes innovation and creative strategies.

Coordination with Subcontractors. Nebraska Total Care utilizes Subcontractors and vendors to oversee specialized activities. Accountability and responsibility for quality are retained by Nebraska Total Care at all times with ongoing auditing to assure our partners perform assigned functions. Vendor Oversight Committees are used to monitor vendor compliance with the Delegation Service Agreement and regulatory requirements, identify issues and opportunities for improvement, review quality and other outcomes, and develop mitigation plans as appropriate. Attendees include vendor representatives and key Nebraska Total Care staff, such as Compliance, Operations, Population Health, Care Management, and QM. The delegated entities provide contractually required reports that include utilization statistics, quality studies, network access, and any issue regarding the delegated function. Member and provider complaints related to vendors are received by our Grievance and Appeals department and investigated and resolved in partnership with the vendor. All delegated entities are audited annually by Centene Corporation's Compliance Team with results reported to the QAPIC. Nebraska Total Care does not delegate QAPI functions.

Quality Assurance and Performance Improvement Committee (QAPIC)

Chaired by the CMO, the QAPIC acts as an oversight committee and receives regular reports from all plan subcommittees that are accountable to and/or advise the QAPIC. The QM department maintains detailed minutes of all quality committee and subcommittee meetings, including evaluated metrics, recommendations and follow-ups, and outcomes of action items. Committee minutes are compiled to provide a summary for review and recommendation by the QAPIC committee. Integrating the work of subcommittees, the QAPIC thoughtfully reviews and analyzes QM projects and progress on the QAPI work plan, recommends policy decisions and action plans, and tracks open issues to resolution. Our local QAPIC is fully aligned with the requirements in Section M.4 of the SOW, meeting at least quarterly with representation from a clinical, member, provider, and quality departments and external stakeholders. The QAPIC includes members and practitioners with various specialties and from different areas of the state. In addition to key staff, current QAPIC participants include:

Individual	Organization
Amy Arndt, DNP, APRN-NP, FNP-C	Hart Family Health
Ann Polich, MD, Chief Medical Officer	CyncHealth (also Nebraska Total Care Board of Directors member)
Hans Dethlefs, MD	Family Medicine, One World Community Health Centers, Inc., Omaha NE
Joni Thomas	Nebraska Total Care staff person with a disability
Roger Wells, PA-C	Physician Assistant at Lexington Regional Health Center

Dental QAPIC. The Dental QAPIC will be chaired by the Dental Director and report to the integrated Nebraska Total Care QAPIC. The Dental QAPIC is responsible for guiding program development, including annual review and evaluation of the Dental QAPI Program Description, Work Plan, and Program Evaluation, and the operational status of quality policy and processes related to dental health. It provides monitoring, evaluation, and recommendation for improved clinical care. Committee members will include Senior Leadership from Nebraska Total Care, as well as external stakeholders. We are actively recruiting a diverse representation of members and dental providers from various specialty areas (e.g., FQHCs, dental hygienists, pediatric dentists) and geographies (e.g., urban, rural, frontier, tribal) as key QAPIC participants. Quality subcommittees will have shared responsibility for integrating the dental program into all aspects of the health plan, and as such will report information to the Dental QAPIC as they do the QAPIC for review, recommendations, and resolution. As all our quality committees do, the Dental QAPIC will fully align with the SOW in section M.8.

Direct Alignment with MLTC's Quality Strategy

Foundational to our QAPI Program is direct alignment with the MLTC Quality Strategy. Nebraska Total Care's QAPI Program and activities are informed by the Quadruple Aim and qualitative and quantitative data, a key source of which is input from

MLTC, including the annual EQRO reports. Our program structure and policies and procedures are also designed and built to meet all requirements in the MLTC Quality Strategy, including reporting requirements and performance measures. We have also adopted recommendations from the HSAG EQRO audit report to improve our performance and service. For example, the use of quality improvement tools such as key driver diagrams, process mapping, and measure testing from CMS.

Quality Focus Areas

Driven by qualitative and quantitative data, Nebraska Total Care selects quality focus areas as part of our annual QAPI Work Plan and throughout the year as opportunities present. Data sources include:

- Prior year performance and reporting, such as our QAPI Evaluation, EQRO audit, and Accreditation reports
- MLTC priorities and objectives
- NCQA quality reports and deliverables
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Patient Care, Access, and Safety Concerns
- Member and provider experience survey results
- Systematic reporting, including:
  - Annual health equity evaluation is driven by our Health Equity Dashboard
  - Over, under, and inappropriate utilization
  - SDOH evaluation using our SDOH Key Performance Indicator (KPI) Dashboard, Neighborhood, Economic, and Social Traits (NEST) predictive model described in Question 66, and community partners
  - D-SNP Model of Care (MOC) measures to determine the effectiveness and implement improvement initiatives
- Subcommittee recommendations

Leveraging Data. Our Enterprise Data Warehouse (EDW) is used to integrate data from internal and external, and clinical and non-clinical sources. Sources include claims, member demographics, provider data trends, health and social needs assessments, and NEST scores. We segment the population into relevant subpopulations and stratify members by risk and demographic characteristics to identify the most prevalent issues, those impacting multiple departments, those most relevant to members with special health care needs or experiencing disabilities, and those relating to racial, ethnic, or regional disparities. This data is then used to inform members, providers, and community-based strategies and programming to resolve care gaps and health disparities. Robust data allows us to be agile in the PDSA cycle, lends confidence to the decision-making process, and improves transparency.

Leveraging our Quality Structure. Creating programs that meet the needs of our members and support heath care in Nebraska requires a collaborative, data-driven, and coordinated approach. Our integrated quality structure ensures that community voices are brought to the table. Nebraska Total Care staff, who live in and understand our communities, partner with members and their support systems, providers, community-based organizations, and Centene's national resources. Bringing together diverse perspectives allows us to approach needs and disparities through a health equity lens. Data metrics guide our decision-making and ensure we all work from an aligned point of need toward a shared goal. The committee format creates avenues for communication and ensures that a large team of individuals stays focused and unified in their shared objectives. Using the QAPI trilogy documents for guidance and evidence-based quality improvement methods, each committee functions independently, but still in partnership with each other.

> "Since it entered the Nebraska market in 2017, Nebraska Total Care has proven itself to be an agile, responsive, and innovative partner to provider organizations. The culture of commitment and respect it has developed has been evidenced time and again in their willingness to be forward-thinking and, more importantly, to work collaboratively. Not only recognizing opportunities to partner to advance care quality but also in recognizing their members as people with unique challenges and needs. From their executive team to their Care Management and CHWs, Nebraska Total Care's focus on member benefit is unwavering. It is my experience that this commitment is genuine."
>
> *- Kelly Weiler, Managed Care Director, Children's Hospital and Medical Center*

Proposed QAPI Work Plan

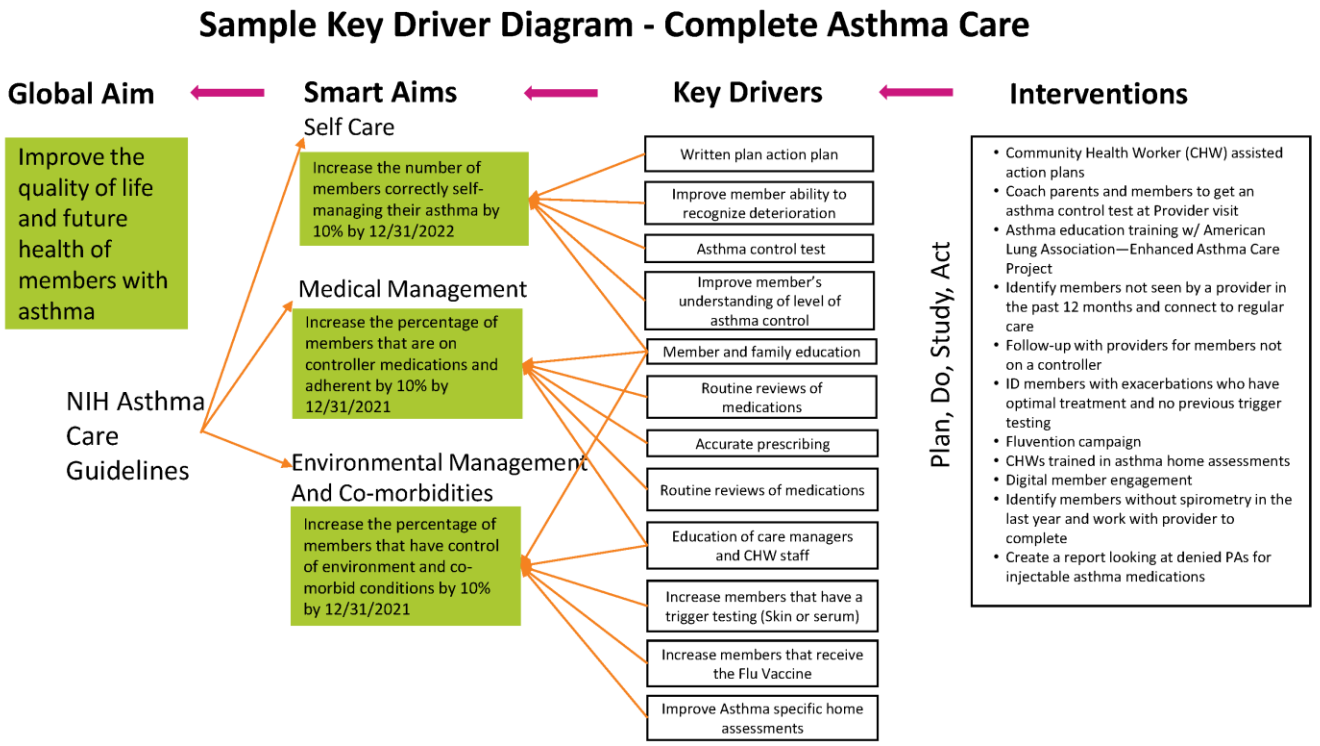
Nebraska Total Care's 2022 work plan is included in **Attachment B.64 2022 QAPI Work Plan**.

65. Describe how the Bidder will measure and track the outcome of individual quality improvement interventions over time.
Page Limit: 3

Measuring and Monitoring Quality Improvement Interventions Over Time

As an NCQA accredited and quality-driven organization, Nebraska Total Care's staff, systems, processes, and tools are centered on our mission to transform the health of our community, one person at a time. We apply a deliberate approach, using reliable and valid methods of monitoring, analysis, evaluation, and improvement. For example:

- The evidence-based Institute for Healthcare Improvement (IHI) Model for Improvement is used to improve health by identifying problems, implementing and monitoring corrective action, and studying its effectiveness
- Plan-Do-Study-Act (PDSA) tests selected interventions on a small scale
- We use the Six Sigma DMAIC (Define-Measure-Analyze-Improve-Control) methodology for improving health plan work processes
- Quality dashboards and other systematic reports provide point-in-time, year-over-year, and quarter-over-quarter reporting of quality metrics for evaluation
- We are integrating the use of Key Driver Diagrams, as illustrated in **Figure 65.A**. to help organize initiatives and uncover causes that contribute to the issue identified for improvement, including primary and secondary drivers to identify actions that are likely to have an impact.



IHI Model for Improvement. The purpose of CQI programs is to improve health care by identifying problems, implementing and monitoring corrective actions, and studying effectiveness. To do this, Nebraska Total Care employs the IHI Model for Improvement. The IHI Model starts with three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

In the second phase of the Model, our staff uses rapid cycle process improvement to test selected high-priority interventions on a small scale and modify them as needed to improve their effectiveness before full implementation. We use data, including structure, process, and outcome measures, to monitor our success in implementing change. We modify, refine, or replace the intervention as needed to improve its efficiency and efficacy and then gradually increase the scale of the intervention until we are confident that it will be more widely successful. Baseline measurement, periodic re-measurement, assessment of success, and documentation of strategies and results are basic components of our improvement model. We re-measure each quality initiative's established performance measures, compare them to the expected standard benchmarks and goals at the intervals determined at the beginning of the intervention, and test the comparisons for statistical significance.

PDSA Rapid Cycle Improvement. PDSA guides targeted measurable interventions and quick evaluation of the impact of an activity on quality and health outcomes. Using the PDSA cycle, we perform analysis, identify best practices, and implement new and revised interventions. We conduct re-measurement at designated intervals to test the changed or new interventions and further redesign or expand them as appropriate. The threshold for sustained improvement is 1) if the level of performance is maintained or further improved one year after significant improvement has been achieved, and 2) if the improvement likely was a result of the project interventions. PDSA interventions and outcomes are documented and reported to MLTC for further collaboration and development as appropriate. If re-measurement does not meet or exceed established goals, the PDSA cycle begins again. In such cases, we evaluate each intervention, identify barriers that may be interfering with the achievement of performance goals, and revise, replace, or supplement the intervention accordingly.

PDSA in Action. In 2020, Well-Child Care (WCC) measures were identified as an improvement opportunity. For the WCC Body Mass Index (BMI) measure, Nebraska Total Care utilized the PDSA process in identifying barriers, prioritizing and identifying interventions, and implementing and measuring progress.

Plan: We evaluated the BMI HEDIS data to assess for provider and member profiling, claims submission issues, and supplemental data opportunities.

Do: Focused priorities included provider education through HEDIS Guides and direct mail outreach explaining the measure.

Study: Subsequent review found a lack of meaningful improvement. In our evaluation of new barriers, we identified data collection errors preventing accurate reporting. We worked with providers to ensure accurate submission and population of data and included the measure in chart reviews for more accurate date collection. Improvement was evident but was not sufficient to meet the goal.

Act: In addition to provider education, member education included BMI screening. Outreach through our Member Care Compass program reminded, assisted, and encouraged well-child visits. Nebraska Total Care provided over 6,200 touches to the member during phone outreach.

Using Data to Drive Improvement. Nebraska Total Care takes a data-driven approach to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and the impact of quality interventions on outcomes over time. Centelligence is our proprietary, comprehensive family of integrated decision-support solutions that facilitate systematic monitoring of data by collecting, integrating, storing, analyzing, and reporting data from all sources. Centelligence provides expansive business intelligence support, including flexible desktop reporting and online KPI Dashboards with "drill down" capability, allowing users to focus on a specific piece of content interactively. Through Centelligence, we report on all internal and external datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, and other critical aspects of our clinical, quality, and administrative operations for all provider types, including physical health, BH, pharmacy, dental, and vision. The following table (**Table 65.B**) and screenshot (**Figure 65.B)** highlight a sample of usable data available to help staff and providers evaluate, monitor, and act on health and quality outcomes. For a comprehensive view of all of our dasboards see Question V.T. 111.

Table 65.B Sample Dashboard Data

Categories	KPI Dashboards
Clinical Indicators	• HEDIS measures • Utilization data: Potentially avoidable ED visits and admits, inpatient length of stay, ED utilization, severity & treatment status of co-morbid chronic medical conditions, over- and under-utilization, regional variations • Member assessments and screenings • Pharmacy data: medication adherence, over-and under-utilization reports, high volume prescribers of opioids • Care management outcomes: program-specific dashboards, NEST social needs predictive model, ED Diversion, NICU diversion, follow appointment after hospitalization
Access Indicators	• Network adequacy, including alignment of cultural and linguistic needs, disability access needs, and SDOH • Geo access reports • Appointment availability audits, after hours access surveys, provider disability access, office site surveys, and appointment no-show reports • Single case agreements and out-of-network reports
Member and Provider	• Member experience: grievances and appeals, CAHPS and ad hoc member satisfaction surveys, Health Risk Screening, SDOH mini screening • Provider experience: complaints and appeals, satisfaction surveys

Categories	KPI Dashboards
Experience Indicators	• Potential quality of care and critical incidents
Disparity Indicators	• Health Equity Dashboard: geographic, race, age, assigned provider
Provider Performance Indicators	• Provider metrics: Provider Portal scorecards, Pay-for-Performance metrics, and incentives • Value Based Purchasing

The following screenshot is from our HEDIS Dashboard which is closely monitored by Quality staff and health plan leadership to inform quality and other improvement activities.

Figure 65.B HEDIS Dashboard Screenshot

	2019 HEDIS Actuals	2020 HEDIS Actuals	2021 HEDIS/CY20		2022 HEDIS/CY21						
Chapter	HED19/CY18 Final STAR	HED20/CY19 Final STAR	CY20 Final Unrounded STAR	CY20 Final Rounded STAR*	1 Yr Ago YTD Unrounded STAR	Current YTD Unrounded STAR	CY20 YTD to CY21 YTD Unrounded STAR Trend	CY21 Proj EOY Unrounded STAR	CY21 Proj EOY Rounded STAR	CY20 Unrounded STAR to CY21 Proj Unrounded STAR Trend	CY20 Rounded STAR to CY21 Proj Rounded STAR Trend
CAHPS	N/A	2.71	4.87	5.00	4.87	4.87	→ 0.00	4.87	5.00	→ 0.00	→ 0.00
HEDIS BH	N/A	2.90	3.20	3.00	3.05	2.82	↓ -0.23	3.40	3.50	↑ 0.20	↑ 0.50
HEDIS Clinical	N/A	2.55	2.86	3.00	1.69	1.68	→ -0.01	3.24	3.00	↑ 0.38	→ 0.00
HEDIS RX	N/A	3.00	3.50	3.50	3.50	3.69	↑ 0.19	3.75	4.00	↑ 0.25	↑ 0.50
OVERALL	**N/A**	**3.63**	**3.91**	**4.00**	**3.29**	**3.24**	↓ -0.06	**4.16**	**4.00**	↑ 0.26	→ 0.00
Consumer Satisfaction	N/A	4.20	4.86	5.00	4.86	4.86	→ 0.00	4.86	5.00	→ -0.01	→ 0.00
Prevention	N/A	2.58	2.64	2.50	1.79	1.88	↑ 0.08	2.91	3.00	↓ -0.29	→ 0.00
Treatment	N/A	3.09	3.22	3.00	2.53	2.44	↓ -0.09	3.33	3.50	↑ 0.47	↑ 0.50

66. Describe experience in using results of performance measures, provider satisfaction surveys, and other data to drive improvements and positively affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes.
Page Limit: 5

Using Quantitative and Qualitative Data to Drive Improvement and Impact Health Outcomes

As referenced throughout our response, Nebraska Total Care is a quality, data-driven organization. We use data analytics available through Centelligence to regularly monitor and evaluate our performance, member and provider experience, quality of care (QOC) and services provided to our members, and health outcomes. In combination with our stakeholder engagement activities, these outcome measures identify opportunities for performance improvement and promote timely access to quality services. Below we describe specific capabilities for capturing and reporting on measure results followed by examples of how we use the results to improve program and member outcomes.

Data Analytics and Informatics Capabilities. Centelligence and our EDW are integrated components of our Management Information System (MIS). Together, they allow for systematic data collection for indicators measurement, data analytics, and reporting to drive action, transparency, accountability, and continuous improvement of our processes. Our EDW systematically collects, validates, integrates, stores, and transmits internal and external data to our core systems. Those systems inform KPI Dashboards described in Question V.M. 65 above for QM, Care Management, Utilization Management, Network Management, and the Call Center. Leaders of each department monitor these metrics daily to ensure compliance with best practice and contract requirements such as turnaround times and call metrics and allow for real-time intervention. For example, Member Services is continuously monitoring hold time to ensure members have timely access to assistance. Increased hold times are identified and assessed for root causes such as system issues, unavailability of staff, or member outreach that increased volume. In those instances, they shift resources to improve response times quickly. They also monitor cumulative metrics to identify trends, such as increased volume on specific days and times, and delegate resources accordingly. Performance results and outcomes data are further shared through our quality committee structure for analysis and recommendations.

Using Data to Drive Performance Improvement. Data is used across the organization and across the delivery system to improve program performance and member outcomes. Our Performance Improvement Team (PIT), an internal cross-functional quality subcommittee that meets monthly to discuss improvement opportunities, uses our systematic reporting and dashboards described in Questions V.M. 64 and 65 above to identify potential areas for improvement, assess member impact, analyze root causes, identify target populations, and test project effectiveness. Department staff use dashboard and analytics capabilities to drive improvement in their areas. For example, Care Management staff proactively identify, stratify, and monitor high-risk members for targeted interventions and document the impact of individual member interventions on progress toward plan of care goals. We support providers with analytics to complete provider peer group comparisons, cost and utilization trending, and quality measure performance, through our secure Provider Portal. Our members are alerted of overdue preventive care through care gap alerts available through the secure Member Portal, Member Mobile App, contact with Member Service or Care Management, and direct outreach through Member Care Compass, our multi-faceted member engagement strategy.

Using Data to Drive Quality Management. We use data-driven QM approaches to monitor the quality and appropriateness of care and services and to drive improvement in all clinical and operational areas. Quality trends and outcomes are reviewed daily by QM staff and reported during all QAPIC and subcommittee meetings. Centelligence supports root cause analysis and allows staff to drill down to the member, provider, or regional level to inform targeted quality interventions. For example, high Emergency Department utilization in given geography can be an indicator of access barriers. In addition, we identify HEDIS scores that are below target and highlight how many members we need to reach to meet our goals.

Driving Performance Through Data and Direct Feedback. Race and ethnicity, living conditions, and limited access to education and income all create health disparities that lead to distinct differences in length of life, quality of life, disabilities, and severity of illness. In addition to evaluating utilization for all members, our Health Equity Dashboard allows us to compare HEDIS rates across population groups and target interventions based on identified disparities in care. In response to our improvement activities driven by these performance measures, we have seen the following improvements:

- From 2019 to 2020, we used our HEI model to reduce health disparities as measured by HEDIS.
- 54.5% reduction in the disparity related to Antidepressant Medication Management - Acute Phase for Hispanic members.
- 73.4% reduction in the disparity in Asthma Medication ratio for Black members.
- 42.4% reduction in the disparity related to Postpartum care for Tribal members.

- 26.6% reduction in the disparity related to Postpartum care for Black members.

Social Determinants of Health. The key to closing health gaps and reducing disparities is the identification and elimination of SDOH needs. Our SDOH KPI Dashboard overlays data from our Social Needs Assessment and Z-codes submitted by providers to create a picture of community needs that can guide meaningful community partnerships, engagement, and investment. To provide services at a member level, our NEST predictive model tool identifies patterns of SDOH needs and looks at population-level indicators. Analyses focus on population characteristics, transportation access, food access, housing quality, socioeconomic status, and education levels, and assist in connecting social needs to physical and mental health strategies. By assigning a NEST score, the tool identified members for direct outreach to assess for and resolve SDOH needs. In 2021, we screened over 5,000 members for SDOH needs and connected to services as needed.

Member Experience Surveys. We conduct annual child and adult annual satisfaction surveys using Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys in addition to interim surveys performed and analyzed by an external party to ensure our satisfaction and experience information is always current and available to inform initiatives. As described in Question V.M.70, specific interventions and initiatives are outlined in our annual CAHPS Action Plan, which is monitored by the PIT, QAPIC, and MAC, and includes staff training, member outreach activities, and health literacy programs. For example, we implemented “Ask Me 3” and created checklists on our website to educate members and give specific directions on how to engage in care with their PCP. As an indicator of our success in measuring and responding to survey results, Nebraska Total Care achieved a five-star rating on Adult CAHPS scores on the first submission. For more real-time feedback, we conduct regular post-contact services following contact with our Member Services staff and use the information collected in those surveys to inform staff training and member and provider education initiatives.

Provider Satisfaction. We assess provider satisfaction across multiple domains, including financial issues, enrollment, communication, education, complaints, claims processing, claims reimbursement, quality, and utilization management processes. Provider survey results are used to identify key drivers and opportunities within an annual Provider Satisfaction Survey Action Plan. Nebraska Total Care has been the leader in provider satisfaction for the last three years. However, each year brings a new set of action plan opportunities. Following is an excerpt from our 2020 Action Plan.

Table 66.A Excerpt from Nebraska Total Care 2020 Action Plan

Domain	Initiative	Outcome
Finance Issues		
2B. Accuracy of claims processing.	1. Leverage Internal Audit monthly claims audit finding report to update systems 2. Implement new work process to track and manage state updates	Health plan claims accuracy improved throughout 2020
2C. Timeliness of claims processing.	Monitor pend volume weekly, ensure 99% pends paid within 30 days	Pends are assigned and worked consistently as core function to meet or exceed standard
Utilization and Quality Management		
3E. Access to Case/Care Managers from this health plan.	Discuss CM availability at Town Halls with Providers, during provider education webinars, provider events, JOC's and provider onsite visits	Integrated CM education provided in all quarterly town halls and external provider trainings throughout 2020
3F. Degree to which the plan covers and encourages preventive care and wellness.	1. Revise P4P plan in 2020 to incentivize key wellness initiatives including A1C and BP control initiatives. 2. Align 2020 VBP with priority QPP and HEDIS measures.	Month over month increases in P4P payouts
Network/Coordination of Care		
4A. The number of specialists in this health plan's provider network.	1. A full validation of the state file to identify specialty provider groups who are not contracted with Nebraska Total Care to support outreach to those providers about joining the network. 2. Outreach to provider groups who are contracted with Nebraska Total Care with practitioners identified on the state file who are not enrolled with Nebraska Total Care for updated rosters and	Network expanded by over 200 practitioners

Domain	Initiative	Outcome
	appropriate credentialing and enrollment.	
4B. The quality of specialists in this health plan's provider network.	Discuss opportunities with VBP partners in Q1 and develop action plans with stakeholder input to execute against.	Monthly quality of care and quarterly JOC meetings with VBP partners to address member needs and improve VBP performance
Pharmacy		
5A. Consistency of the formulary over time.	Biannual email or fax blast to providers informing of upcoming formulary changes, posted on Nebraska Total Care website provider page.	Pharmacy communciations delivered via provider news, fax/nesletter blast as scheduled
5D. Ease of prescribing your preferred medications within formulary guidelines.	Standing agenda item on weekly internal pharmacy meeting and external Pharmacy Benefits Manager meetings to ensure resolution and continued monitoring of any known utilization management procedure issues.	As a result of the continued collaboration to decrease provider administrator burden, automatic prior authorization edits were implemented resulting in operational efficiency and a 41.6% reduction in number of PAs submitted from January to December 2021
Health Plan Call Center Service Staff		
6A. Ease of reaching health plan call center staff over the phone.	Maintain SLA's above 90% of all calls answered in 30 seconds or less	SLA's consistently met month over month, exceeding SLA of 90% in 2020
Provider Relations		
7A. Do you have a Provider Relations representative from this health plan assigned to your practice?	Maintain PR Geo Maps on website for PH and BH provider areas	PR maps are current and identified in provider trainings (two Town Halls done in Q2)
7B. Health plan's ability to answer questions and solve problems related to core business functions such as claims, eligibility, and prior authorizations.	Nebraska Total Care will support internal cross-department training on systems and key operations updates (i.e.: Medicaid Expansion) to support PR staff ability to answers provider questions accurately.	Weekly tag up meetings are being held to promote interdepartment communication/info share; provider news posts for standard messaging

In 2022, we are focused on the following items as driven by survey results, all scheduled to be complete by October 2022.

Table 66.B 2020 Focus Items

Initiative	Description	Expected Outcomes
Access to Case/Care Managers	Increase the frequency of education on case/care manager roles and the appropriate ways to request member enrollment into the Care Manager program.	Increased provider awareness of when it is appropriate to make a Care Management referral, as well as the process to do so. The provider can make a direct referral in the Provider Portal
Timeliness to answer questions and/or resolve problems	Improve tracking of the timely response and resolution of inbound provider outreaches to their PR Rep or Network Rep.	Improved tracking of completion of provider outreaches directed to PR and Network mailboxes.
Overall satisfaction with the health plan's call center service	Provider Services to focus on quality elements associated with first call resolution	Develop and deliver training specific to educating providers from trending identified through call quality audits to support first call resolution. Partner with Provider Relations and Contracting Teams on topics to include in training to assure provider questions are answered and direct the caller to the most efficient avenue (portal, call center, vendor/partner) for resolution

Initiative	Description	Expected Outcomes
Timeliness to resolve complaints	Continue to enhance employee retention in the call center and will expand redundancies in place for reduction of hold time and improvement of service level.	Increased ongoing training and call monitoring. Improved tools, reporting, and cross-departmental upskill training to support first call resolution.
Timeliness of obtaining pre-certification/referral / authorization information	Support the continuous quality improvement of UM auth processes to support Turn Around Times that avg. <5 days for OP services (NCQA requirement is w/in 14 days for OP services). Identify opportunities for authorization automated approvals based upon clinical criteria.	Improve provider communication and transparency related to the necessary documentation to finalize a determination without requesting additional documentation.
Ease of prescribing preferred medications within formulary guidelines	The composition of drugs on the formulary should represent a robust offering of therapeutic areas for self-administered drugs. Prescribers should have access to formulary information including preferred alternatives and clinical criteria for coverage. Formulary changes should be communicated on time to providers. Implementation of automatic prior authorizations (APA) at point of sale.	Improved communication to providers on formulary changes and alternatives. Ensure the website has the most up-to-date formulary, clinical criteria policies, and prescriber scorecard posted. Increased utilization of the weekly provider email, and collaboration with VBPs and providers to convey formulary changes and preferred PDL products. Decreased provider administrative burden based upon APA implementation.
Accuracy of claims processing	Ongoing configuration and benefits audits will continue to improve the auto-adjudication rates as well as payment accuracy.	Improved auto-adjudication rates and payment accuracy.

Grievances and Appeals. Grievances are grouped into categories that allow us to track and trend data. Tracking categories include availability and accessibility of services and providers, utilization and case management services, QOC, and covered benefits. Data is reviewed monthly by QM and presented to the PIT, along with quarterly comparative data. When trends are identified, the PIT may perform a root cause analysis and make recommendations to the QAPIC. Additionally, the grievance process and trend data are reviewed annually with the Member Advisory Committee for recommendations. During the annual QAPI program evaluation process, Grievance and Appeals and QM staff assess data by category to identify trends and plan or provider level improvement opportunities and develop interventions for the Annual Work Plan.

Identifying Systematic Issues and Making Programmatic Improvements

Based on the methods described, Nebraska Total Care makes programmatic improvements to improve outcomes and experience. For example, many of the programs in place today are in direct response to member and provider feedback, such as our Provider and Patient Analytics tools available on the secure Provider Portal, Notification of Pregnancy forms, credentialing process, authorization process, and prior authorization list. Other more recent examples include:

Table 66.C Programmatic Improvements

Issue Identified	Method of Identification	Description/Intervention	Outcome
Pregnancy notification	Direct Provider Input	Providers expressed concerns about completing a separate Notification of Pregnancy (NOP) form versus the state OB Needs Assessment Form (ONAF). We expanded our existing program to include the ONAF, offering incentives for ONAF completion and submission during the 1st and 2nd trimesters.	NOP/ONAF receipts have increased by 20.3% from 2018 to 2021, with more members accessing prenatal care including a 15.1% increase in the average number of prenatal visits from 2018 to 2021.
After hours phone calls	Member Advisory Committee (MAC)	Members were identified where transportation was not available to take members to COVID-19 vaccine clinics outside of a provider's office, preventing access to the vaccination.	Immediate planning with the transportation company led to a change in the transportation policy and full access to COVID-19 vaccination clinics within 24 hours.

Therapy Services	Provider Advisory Committee (PAC)	In choosing a vendor to administer the Therapy Utilization program through post-pay review processes, associations expressed concerns through the PAC.	In response to this input, we: • Enacted a policy of administrative authorization for 12 sessions of therapy for post-op patients • Returned therapy authorizations to a locally managed program with Nebraska Total Care utilization reviewers. • Reduced or removed PA requirements for PT/OT/ST evaluations and created an administrative approval process for the first five sessions. • Increased the length of time authorizations are valid, thereby decreasing concurrent reviews for continued care requests. In July 2022, we will configure our system to automate this authorization, eliminating the need for requests and approval processing.
Transportation Barriers	Weekly MTM meeting	Member and provider identified to MTM that the provider-required Level of Need (LON) form was becoming a barrier to accessing transportation.	The assessment determined that the form was not providing substantive value and the requirement was removed.
Coordination with LTSS waiver providers for non-dual members who are waiver-eligible	Coordination meeting with Area Agencies on Aging	Actively engaging with Area Agencies on Aging and the League of Human Dignity to propose a new way of working collaboratively that includes an early identification on our end and a check-in with the member, extending to ongoing reoccurring case rounds on select members.	In development but committed to dedicating staff based on stakeholder feedback.
Opioid Prescribing	Provider Performance	Identified inappropriate prescribing and dispensing practices and launched a multi-prong Opioid Dosage Tapering education campaign consisting of JOC meetings, written materials to all providers, and an opioid resource page on our provider webpage, and edits at POS for claims exceeding the 90 MME threshold.	Since 2018, we have driven a 48% reduction in opioid prescriptions per thousand members, a combined savings in 2019 and 2020 of $2.1 million in opioid spending safely without compromising their diagnosed needs for opioid medication
Limited access to specialist	Children's CAHPS survey and network adequacy reports	CAHPS surveys for children consistently identify "access to a specialist" as an area of lower satisfaction. In much of the state, network adequacy reports support the need for additional access.	Implementation of ConferMED, providing telehealth consultation with Medical Specialists to PCPs.
Limited report of SDOH needs by providers	Nebraska Total Care data	The development of the SDOH KPI Dashboard identified a clear need for more competitive data.	Providers can identify a member as food or housing insecure by submitting diagnosis codes such as Z59.0 (Homelessness) or Z59.1 (Inadequate Housing) to receive an incentive payment.

67. Describe how the Bidder will assess the quality and appropriateness of care furnished to members including special health care needs, members with co-occurring physical and behavioral health concerns, and dual-eligible members.
Page Limit: 3

Assessing the Appropriateness and Quality of Care

Expanding Access to High-Quality Services

Nebraska Total Care's mission is to transform the health of the community, one person at a time. As part of our Quality Assessment and Program Improvement (QAPI) Program, we have the infrastructure, systems, processes, and tools to assess and monitor the quality and appropriateness of care provided to our members. This includes analyzing, reporting, and acting on clinical and non-clinical outcomes for individuals with special health care needs, individuals with co-occurring physical and behavioral health (BH) conditions, and individuals who are dually eligible for both Medicaid and Medicare.

Our data-driven QI practices include methods to effectively evaluate and report quality measurement results, such as HEDIS, which are key indicators of effective and appropriate service delivery. Using our HEDIS Dashboards (screenshot provided in Question V.T. 111), we routinely monitor, track and trend HEDIS performance. We can distinguish members with special health care needs, members with co-morbidities and duals, and can filter and segment our HEDIS reports by population segments. For example, Nebraska Total Care improves the care members receive by monitoring and improving the rate of preventive and treatment services to control chronic conditions. We also generate monthly HEDIS-like reports, using administrative data, to track performance toward goals and identify care gaps for individual members. Additionally, our Health Equity Dashboard displays performance across HEDIS measures by race and ethnicity. Population Health staff review these reports monthly and the QAPIC quarterly to identify and address trends and monitor improvement initiatives.

Utilization Patterns and Trends. We analyze timely and actionable data to assess and monitor the quality and appropriateness of care, identify disparities, determine improvement focus areas, drive interventions, and evaluate results. Our Data Analytics Team produces daily, weekly, monthly, quarterly, and annual reports for easy monitoring and trending against benchmarks over time, including review of network performance and drill-down reports that may reflect potential under or over-utilization of service at aggregate and sub-population levels. Using a closed-loop process, we compare services authorized to services received and continuously look for inequities in access to services.

Our Centelligence reporting and analytics platform is our proprietary, comprehensive family of integrated decision-support solutions that facilitates systematic data monitoring by collecting, integrating, storing, analyzing, and reporting data from all sources. Centelligence provides comprehensive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with "drill down" capability, allowing users to focus on a specific piece of content. For example, our Clinical Initiatives Dashboard, illustrated in **Figure 67.A**, aggregates claims, assessments, and administrative data to analyze member patterns and trends for a 360 view of members. The Clinical Initiatives Dashboard enables our Care Management team to track metrics such as timeliness of outreach to high-risk pregnant members, sickle cell assessment rates for individuals with sickle cell disease, and behavioral and medical post-hospital outreach and follow-up rates.

[redacted]

Table 67.B provides additional examples of KPI reports that various Departments and Quality Committees use to assess and monitor the quality and appropriateness of care.

Patient Analytics for Providers. Powered by Centelligence, we deploy dashboards and analytic tools that enable our providers to have a 360° view of their patients that supports the delivery of quality care and optimal health outcomes. Patient Analytics is a web-based tool available to our providers through our secure Provider Portal. Patient Analytics offers providers access to care gap information, physical health and BH diagnoses and medication, lab, and care team data on an individual member level. Patient Analytics offers easy-to-build reports, allowing providers and their care team the ability to engage with actionable patient-level data, in the manner and format best suited to their needs. For example, Patient Analytics enables providers to sort patients by multiple metrics simultaneously such as dual-eligible patients with an immunization care gap. They can also view specific patient metrics including claims history, disease condition, and non-compliance with quality measures to identify high-risk members. In addition to these tools and reports, we also convene regular monthly care coordination meetings with our providers in VBP to discuss complex members such as individuals with co-morbid physical and BH conditions and high utilizers of the ED.

Patient Safety. We also monitor the safety of our members through the identification of potential and/or actual Quality of Care (QOC) events. QOC events are defined as any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including the death of a member. We have established systems and processes in place to conduct a thorough review on any quality and/or safety of care concern identified internally or reported externally by a provider, member, or the member representative. Safety concerns are scored, trended, and acted on as appropriate.

Clinical Practice Guidelines (CPGs) Adherence. Providers are contractually obligated to adhere to Nebraska Total Care's published guidelines and are monitored for compliance through random chart audits. For example, for population-based analysis, adherence is assessed via claims data or HEDIS rates. For practice-based analysis, a sample of medical records may be evaluated for adherence to specific guidelines. If performance measurement rates fall below Nebraska Total Care's and/or MLTC goals, corrective action plans and/or interventions are implemented for improvement, as applicable. Potential QOC events are investigated and may include evaluation of compliance with evidence-based practices where applicable.

Member and Provider Experience. Our Quality Department analyzes monthly reports of member grievances, provider complaints, and appeals, as well as annual member and provider satisfaction surveys and input from our Member Advisory Council, and Clinical and Provider Advisory Committees to identify potential issues with the provision of medically necessary services and appropriateness of care. The Quality Department forwards identified trends to the QAPIC for recommended corrective action. For example, a review of grievance and appeal data revealed one complaint related to the accessibility of a pediatric specialist. We expeditiously resolved the grievance by authorizing out-of-network services and assigning a care manager to the member to serve as a single point of contact throughout the authorization and care management process. As part of our Quality Improvement plan, we also conduct an annual Consumer Assessment of Health Plans Survey (CAHPS®), and a Behavioral Health ECHO® survey to identify member experience issues and opportunities for improvements and stratify member satisfaction results according to race, ethnicity, and language preference to identify member satisfaction issues that disproportionately impact specific groups of members. We also conduct annual Provider Satisfaction Surveys, which direct process improvement activities for administrative simplification and better service to providers.

Care Management Monitoring and Evaluation. Nebraska Total Care's care management program includes systems and people to monitor member receipt of recommended care at an individual member level. Our Care Managers schedule follow-up discussions with members and review the member's plan of care at each interaction, confirming receipt of services and that the services continue to meet the member's needs. We also monitor and report care management activities and outcomes regularly through dashboards and reports generated from Centelligence that aid us in assessing the appropriateness of care at the right time and in the right setting.

Ensuring Oversight and Accountability

The QAPIC acts as an oversight committee and receives regular reports from all plan subcommittees that are accountable to and/or advise the QAPIC. The QAPIC provides oversight and direction in assessing the appropriateness of care and services delivered which continuously enhances and improves the QOC and services provided to members. With oversight from our Chief Medical Officer, our QAPIC brings our quality, pharmacy, member services, provider services, care management, compliance, and utilization management staff together to thoroughly review and analyze reports to assess and identify opportunities for improvement by:

- Monitoring QA Program compliance and assessing provider compliance with our UM and clinical practice guidelines
- Reviewing data at aggregate and detail levels, such as by member, individual provider or facility, provider specialty, service type, diagnosis, and by comparing services authorized to services received
- Using advanced analytics tools to evaluate trends in service utilization that may indicate health inequities and take actions to ensure all members have timely access
- Analyzing total utilization, and utilization of specific services concerning others, such as ED utilization relative to outpatient preventive services, or BH psychotropic medication use about diagnosis and long term use
- Identifying issues by comparing utilization performance to peer groups, overall network performance, and benchmarks
- Presenting data to our quality committees, such as the Provider Advisory Committee, Clinical Advisory Committee, Behavioral Health Advisory Committee, and Health Equity and Diversity Committee, for further review and recommendations

Additionally, as discussed in our response to Question V.M. 64 above, we will establish a separate Dental QAPI Program and committee infrastructure. These functions will report up through our quality infrastructure to ensure appropriate alignment, integration, and coordination. The overall scope and goals of our Dental QAPI are like that of our QAPI, with a focus on access to and quality of dental care, including accessibility, availability, timeliness, and clinical appropriateness of care and services provide through dental providers.

68. Describe the Bidder's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the Bidder's quality of care delivery.
Page Limit: 2

Soliciting and Using Feedback and Recommendations to Improve Care Delivery

Stakeholder engagement and feedback are essential to serve our members and those who care for them effectively. We engage members, families, providers, advocates, and community stakeholders through various means, including ad-hoc outreach, committees, forums, community education activities, and surveys. We use this feedback to develop thoughtful, meaningful, and evidence-based program improvements. Described below are processes and methods we use to solicit feedback and recommendations to improve the quality-of-care delivery.

Member Advisory Committee (MAC). As described in detail in Question V.M. 75, Nebraska Total Care's MAC is used to obtain feedback from members and their families to drive engagement, population health, and quality improvement strategies. MAC membership includes members, families, and other key stakeholders that best represent our membership. We ensure the MAC is diverse and representative of Nebraska Total Care's membership concerning race, ethnicity, language, age, geography, eligibility category, and health status, understanding how critical member feedback is to reduce health disparities and advance health equity. Current participants include 14 members and representatives from Aging Partners, Public Health Association of Nebraska, Public Health Nurses, NE Statewide Independent Living Council, Encore, and the North Central Department of Health.

We document action items and input from each MAC Meeting to inform initiatives and report back on progress. We have a closed feedback loop where information from MAC meetings is directly shared at the QAPIC quarterly to further drive and support quality improvement across the health plan and delivery system. The QAPIC oversees this closed-loop approach to ensure the member's voice is prominent in all of our operations and activities. Additionally, we report to MLTC semi-annually on MAC activities, including meeting dates, agenda, minutes, and attendees; recommendations developed by the MAC; and Nebraska Total Care's response to the MAC recommendations.

For example, we learned from MAC input that members did not like to receive calls from Nebraska Total Care during the dinner hour. At the next MAC meeting, we shared that we worked with the outbound teams to program all calls to be complete before 5:00 pm. As another example, members expressed concerns that the transportation company would not take them to COVID-19 Clinics that were not affiliated with hospitals or physician offices. Based on this feedback, we worked with our transportation vendor to approve transportation to all COVID-19 vaccination clinics.

Member Experience Surveys. Nebraska Total Care conducts annual child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and interim surveys performed and analyzed by an external NCQA-approved vendor. The Child and Child with Chronic Conditions are further surveyed per state contract by Title 19 and Title 21. We analyze and use results and findings from the annual CAHPS surveys to drive improvements to how care is delivered, as described in detail in Question 70. For example, we implemented "Ask me three" and created checklists on our website to educate members on how to engage in care with their PCP, based on findings from the CAHPS surveys.

Care Management Satisfaction Surveys. Nebraska Total Care conducts an annual Care Management survey to assess satisfaction and request feedback from members enrolled in Care Management. We use survey responses to identify opportunities to make programmatic improvements. We contact members directly to address any concerns or challenges they include in their responses. Annually, our Population Health Management team compiles responses and reports an analysis of survey results to the QAPIC to identify opportunities to improve the Care Management Program.

Family Member Feedback. Nebraska Total Care encourages family members to provide feedback through multiple methods. Where applicable, we solicit feedback from parents and authorized representatives through the same mechanisms we use to obtain member feedback, including surveys and the MAC. We invite MAC members to bring a guest, often a parent or family member, to share their perspective, and we use that feedback to identify opportunities for new programs and program improvements. For example, Duet is a community partner that supports individuals experiencing developmental disabilities. They identified a caregiver gap in information and hosted a caregiver event entitled "Having Difficult Conversations" to guide caregivers through the process to make a plan for the care of their loved one if they become unable to do so and to communicate that plan so their family member understands and feels comfortable. We worked with Duet to promote the event, including outreach to our membership, providing a mental health professional to support the discussion, and offering incentives for participation.

Soliciting Stakeholder Provider Feedback. Nebraska Total Care knows that our providers bring essential perspectives and ideas based on their experiences caring for our members. We regularly solicit advice on specific policies and program design

and maintenance, as well as ideas on how to help our providers care for patients, implement guideline-based care, and lower their administrative burden. We make every effort to obtain input from provider stakeholders across the State who represent urban, rural and frontier areas; primary, specialty, and behavioral health (BH) care; hospitals, large and small provider groups, and independent providers; physicians, nurses, physician assistants, and pharmacists. Nebraska Total Care staff, including our Provider Relations, Quality, and Pharmacy teams, are actively engaged with providers across the State, constantly seeking to learn more about their priorities and pain points. They regularly participate in peer-to-peer conversations, local medical associations, statewide multi-stakeholder health care collaboratives, and hospital-based quality and education programs. Our leadership maintains a line of open and bi-directional communication with our providers, facilitating collaboration to address both immediate problems and long term systemic issues.

Committee Participation. We have multiple outlets for deliberately collecting provider feedback, including our Board of Directors, with 12 providers from diverse geographies and practice areas; various Quality Committees; Joint Operating Committees (JOCs); surveys, QAPI, several of which are described below and in detail in Question V.M. 66 and 72. Nebraska Total Care views our operational committees, including Pharmacy and Therapeutics, Credentialing, Quality Improvement, and Clinical Advisory Committee, as an essential part of our health plan. Each of these committees includes external network providers as well as Provider Relations and other health plan staff. These external providers are valuable contributors and voting members. Provider Relations directors and managers, along with other operational departments, also hold regular Joint Operations Committee meetings with hospitals, providers under value-based contracting arrangements, health systems, and facilities. We have external providers represented on our physician-led Board of Directors to gather their opinions on our policies, processes, and programs. Nebraska Total Care's PAC meets quarterly to provide recommendations on patient care, policy, and innovation. The PAC serves as an essential mechanism to discuss regional and statewide issues, challenges, and barriers impacting providers and to identify opportunities to solve those problems.

Provider Surveys. Nebraska Total Care also leverages survey feedback through the Annual Provider Satisfaction Survey, conducted by an independent third party, and through surveys administered after each call to Provider Services, to drive program improvements. Provider survey results are used to identify key drivers and opportunities within an annual Provider Satisfaction Survey Action Plan. For example, respondents to the 2021 Provider Satisfaction survey indicated an opportunity for improvement in answering questions and/or resolving problems. In response, we implemented new systems to improve tracking of the timely response and resolution of inbound provider outreaches to their Provider Relations Representative.

Soliciting Community Stakeholder Input and Engagement. Cross-system coordination and local engagement are core values of our model. We promote collaboration and collective input from community stakeholders via established feedback loops, dedicated staff liaisons, and engagement in local community stakeholder meetings and forums. For example, our community partner Buffalo County Local Health Department shared their concern about the lack of cultural competency for community-based organizations in their county. In response, Nebraska Total Care, in collaboration with Buffalo County Local Health Department, provided the training and 85 local representatives attended. Other counties saw the success, and opportunities are being created in additional rural and frontier communities.

Closing the Loop on Feedback

We have established systems and processes in place to address and close the feedback loop. This includes the use of performance improvement teams and committees to track action items and ensure follow-up at subsequent meetings. We also complete a program evaluation annually of quality activities and outcomes. Additionally, we ensure members/families/caregivers, providers, and stakeholders are provided with information on what we did as a result of their input to improve quality using multiple avenues such as our Quarterly Impact Report which highlights new programs and initiatives which we post on our public website; use of member and provider news; Member and Provider Newsletters, provider town halls and quarterly JOC meetings.

69. Describe the Bidder's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the Bidder, and how operations improved because of their results. Discuss how the Bidder will collaborate with MLTC and other MCOs to conduct statewide PIPs.
Page Limit: 3

Performance Improvement Projects

Performance Improvement Projects (PIPs) are an integral component of our quality assessment and performance improvement (QAPI) program designed to achieve statistically significant improvement in health outcomes and member satisfaction sustained over time. Since the inception of Heritage Health, we have successfully designed, implemented, and evaluated five PIPs that focus on a range of topics including Follow-up after an Emergency Department (ED) visit for mental health illness or Substance Use Disorder; Initiation of 17- Hydroxyprogesterone (17P) in pregnant women; Tdap vaccination in pregnant women; Diabetes screening for members diagnosed with schizophrenia or bipolar disorder on antipsychotic medications (HEDIS SSD), PCR and in 2022 started a new Notification of Pregnancy (NOP) PIP. To date, we have successfully met the state's EQRO PIP validation criteria for our PIPs, demonstrating that our PIPs are built, implemented, and evaluated using a strong foundational framework and methodology.

Methodology to Identify, Design, Implement and Evaluate PIPs. Informed by our Health Equity Improvement Model (described in detail in our response to Question V.M.73), our PIPs are designed, conducted, and reported in a methodologically sound manner that meets all PIP-related MLTC and CMS requirements. We use ***HSAG's EQRO protocols and the Plan-Do-Study-Act (PDSA) cycle,*** described below, to identify, design, implement and evaluate our PIPs.

EQRO PIP Protocols

1. **Select the PIP Topic** based on data indicating an opportunity for improvement and the potential for improving member health, functional status and/or satisfaction.
2. **Define the PIP Aim statement** with measurable terms that functions as a framework for data collection, analysis and interpretation.
3. **Define the PIP Population** to which the PIP Aim statement (s) and measurable indicators apply. The definition of the PIP population includes requirements and parameters such as enrollment criteria, member demographics, diagnosis criteria, etc.
4. **Use Sound Sampling Methods** to ensure valid and reliable results in accordance with generally accepted principles of research design and statistical analysis.
5. **Select the Performance Indicators** that are objective and clearly defined to track performance or improvement over time.
6. **Valid and Reliable Data Collection** methodology that includes the identification of data elements and data sources; when and how data will be collected and used.
7. **Indicator Results** that include data analysis and interpretation of results.
8. **Data Analysis and Interpretation of Results** that includes documentation of each indicator with a narrative description and statistical testing.
9. **Improvement Strategies** that include interventions to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

PDSA Methodology. Our PIPs are designed to achieve and sustain significant improvement over time following principles of sound research design and appropriate statistical analysis. Once designed, we use the PDSA cycle in **Figure 69.A** to perform analysis, identify best practices, and implement new and revised interventions as appropriate. We monitor and evaluate each PIP's performance measure, compare them to the established benchmarks and goals at the intervals determined at the beginning of the project, and test the comparisons for statistical significance. Intervals are based on the timeframe in which an anticipated improvement in performance is expected to occur. Following the PDSA model, progress is evaluated and presented to multidisciplinary workgroups and reported to the QAPIC for input and development of strategic actions to drive improvement and/or address any identified barriers. The root cause, barrier analysis, and recommendations for changes and/or modifications of methodology are solicited at these meetings. The QAPIC is also responsible for assessing whether activities are being completed promptly or if a revision in interventional methodologies is required.

Figure 69.A PDSA Cycle

We conduct re-measurement at periodic intervals to test the changed or new interventions quickly and implement process improvements, as appropriate. We consider improvement to be sustained if the level of performance is maintained or further improvement occurs one year after significant improvement has been achieved and if the improvement likely was a result of the project interventions.

As part of our process, we maintain successful interventions and report them to MLTC as possible best practices for other Managed Care Organizations (MCOs) consideration. If re-measurement does not demonstrate significant improvement and performance does not meet or exceed established goals, the PDSA cycle begins again. In such cases, we evaluate each intervention, identify barriers that may be interfering with the achievement of performance goals, revise the intervention, or replace or supplement it with new interventions to address identified barriers. Our PIP intervention results drive the next steps and inform whether they should be continued, expanded, revised, or replaced.

Examples of our Experience Successfully Administering PIPs

Nebraska Total Care has significant experience conducting PIPs. Highlighted below are examples of two PIPs we conducted and how our operations improved because of their results.

Tdap Vaccination in Pregnant Women PIP. One example of a PIP topic that we have successfully implemented that ***yielded improvements in care is our Tdap Vaccination in Pregnant Women***. The incidence of pertussis has gradually increased in the United States since the 1990s. This topic is important to our member population because the state of Nebraska had the highest incidence of pertussis per capita of all states in the United States. Outbreaks of pertussis lead to morbidity, complications, hospitalizations, and mortality, and those at greatest risk for Pertussis are young infants.

In response to this opportunity, working collaboratively with MLTC and the other Heritage Health MCOs, we participated in a statewide PIP to reduce the rate of pertussis in women and babies by administering Tdap vaccinations to pregnant women, recognizing that vaccinating pregnant women is effective in providing passive immunity to their unborn child. To meet or exceed the goals established by MLTC for this statewide PIP, we designed and implemented a multi-pronged provider and member outreach and education program to improve the percentage of Tdap immunizations during pregnancy.

Evaluation and Results. As a result of the interventions, our data analysis from CY 2020 ***found an improvement in Tdap vaccination, both overall and during the optimal gestational age period.*** We successfully improved the percentage of members who received the Tdap vaccine at any time during pregnancy by 13.5 percentage points from baseline to Final Measurement Year CY 2020 and exceeded the targeted goal. Additionally, the percentage of members who received the Tdap vaccine during 27–36 weeks of pregnancy also increased by 2.9 percentage points from baseline to Final Measurement Year CY 2020.

Table 69.1 Tdap Vaccination in Pregnant Woman PIP

Indicator	Baseline Period CY 2017	Interim Period CY 2018	Interim Period CY 2019	Final Period CY 2020	Goal
Indicator 1: Receipt of Tdap during pregnancy	53.00%	64.51%	64.38%	66.50%	65.19%
Indicator 2: Receipt of Tdap during 27–36 weeks gestational age period	46.32%	55.30%	50.51%	49.19%	59.98%

Improvement strategies/Enhanced Interventions. As noted above, although we met the goal and demonstrated improvement in the receipt of Tdap vaccines in pregnant women, we did not meet the goal of indicator 2- receipt of Tdap during the 27-36 weeks gestational age period. In response, following Interim results reported in CY 2019, using our PDSA cycle we modified our interventions based on identified provider and member barriers that included a lack of provider/office staff knowledge on best practice guidelines involving Tdap in pregnancy, billing, and reimbursement, and benefits to newborns and timing of immunization during last trimester. In response to these barriers, we conducted targeted provider education interventions to improve Tdap vaccination rates that included provider training, town hall meetings, use of joint operating committees, provider communications, and provider relations outreach that included targeted information on the PIP project, American College of Gynecology (ACOG) and Advisory Committee on Immunization Practice (ACIP) guidelines, Tdap coding, and Vaccine for Children's program. We also identified member barriers such as

lack of knowledge by members about the benefits of Tdap vaccination during the last trimester of pregnancy. In response, we conducted additional interventions such as member outreach and education on the Tdap vaccine during pregnancy as part of our comprehensive Start Smart for Your Baby prenatal case management program, targeted emails, and through care coordination contacts with pregnant members.

Operational Improvements. As part of our PDSA cycle, although we retired the Tdap in Pregnancy PIP on December 31, 2020, we are continuing our efforts to educate our members and providers on the importance of Tdap vaccinations in pregnancy, utilizing several of the interventions described above that were determined to be effective. Additionally, in response to feedback from providers regarding low reimbursement rates for the administration of the Tdap vaccine, we worked collaboratively with MLTC to adjust the reimbursement rate to address this identified provider barrier and concern. Lastly, informed by learnings from the Tdap PIP, we implemented our plan-wide Member Care Compass initiative that includes a cross-departmental committee, to further enhance our member engagement activities using a multi-modal approach that includes a seamless and coordinated member experience.

Notification of Pregnancy PIP. Nebraska Total Care recognizes the key role we play in ensuring pregnant women have access to adequate prenatal care and supports and services that support a healthy pregnancy and positive birth outcomes. We are committed to collaborating with MLTC, our provider partners, community-based organizations, and key stakeholders to increase access to prenatal care, improve birth outcomes, and reduce infant mortality for our members. This includes implementing a ***new Notification of Pregnancy PIP in 2022 that supports MLTC's*** maternal and child health policy goals. The new NOP PIP aims to increase access to prenatal care services through the early identification of members who are identified as pregnant and ensure they have access to prenatal and postpartum services. We know from experience that the timely completion of the state's NOP form is an effective way to identify and link pregnant women to appropriate care and services. Based on input from MLTC and the EQRO, our goal is to increase the number of completed NOP forms on expectant mothers who will deliver by year-end in 2023 by 3%.

Informed by our Health Equity Improvement Model described in Question V.M.73, our interventions for the NOP PIP build upon our established initiatives and programs, such as our multi-faceted member and provider outreach and education campaigns and our Start Smart for Your Baby prenatal Care Management Program, designed to improve birth outcomes. For example, we are collaborating with our communities, providers, and other MCOs to implement a Pathways Community HUB model, which is an evidence-based, outcomes-payment care model. The HUB's pay-for-performance service-delivery model improves health outcomes by developing a "pathway" to remove barriers to care, assist with SDOH, and attach individuals to primary and specialty care. Nebraska Total Care is part of the core team that is working to bring a HUB entity to Douglas County, which has high rates of health disparities. Focused first on maternal and infant health, the HUB will provide support and education and use life experience to help connect members to community resources through trained CHWs. Currently, we educate members and providers about how to complete the NOP form in our Member Handbook, Provider Handbook, and on our website. As an enhancement, based on best practices from our affiliate health plans, starting in 2022 we are incentivizing members to complete the NOP form through our My Health Pays Program which includes a reward of $15 for completion of the NOP during the first trimester of pregnancy and $10 for completion of the NOP form in the second trimester of pregnancy. ***Beginning in 2023, we will offer an enhanced value-added benefit for pregnant members to submit a NOP at least 60-days before delivery. Upon receipt of the NOP, members will be allowed to choose a car seat, stroller, pack-and-play, or meal delivery service.***

Collaboration with MLTC and other MCOs

Nebraska Total Care is committed to working in collaboration with MLTC and the other MCOs to identify and design state-led PIPs, including dental PIPs as part of the new RFP requirement. As a current Heritage Health participating MCO, we have a long history of working alongside MLTC and the incumbent MCOs to design and implement several statewide PIPs in a manner that leverages best practices, fosters collaboration, and minimizes provider abrasion. Specifically, from 2018 through 2020 Nebraska Total Care actively participated in monthly PIP meetings with MLTC and the other two Heritage Health MCOs. The meetings were instrumental in identifying systemic barriers, collectively identifying potential solutions and community and state resources, and sharing data and information among all MCOs to proactively identify trends and issues. For example, Nebraska Total Care worked with the other two MCOs on a clinical data exchange initiative to access ED information through Nebraska's Health Information Exchange (HIE), CyncHealth, to support reporting and analysis for the statewide Follow-up after Emergency Department (ED) visit for mental health illness or Substance Use Disorder PIP.

Substance Use Disorder Improvement

As a result of this intervention and collaboration, Nebraska Total Care saw an improvement in our HEDIS FUA follow-up after ED visit for substance abuse issue – 7 day / 30 day- an 8.28 percent in 7 days and 10.45 percent increase in 30 days from MY 2018 to MY 2021.

70. Discuss the Bidder's approaches to annual member satisfaction surveys. Provide relevant examples of how the Bidder has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.

Page Limit: 2

Approaches to Annual Member Satisfaction Surveys

We use standardized member satisfaction tools and surveys to collect information on members' experiences with health plan programs, operations, services, and access to care. Information collected through these surveys is used to improve staff training, member outreach activities, and member materials, including topics for Member Newsletters.

CAHPS Member Satisfaction Surveys. Nebraska Total Care conducts annual child and adult annual satisfaction surveys using Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and interim (off CAHPS-year surveys) performed and analyzed by an external party to ensure our satisfaction and experience information is always current and available to inform initiatives. For Measurement Year 2021, Nebraska Total Care received top box scores on Getting Care, Rating of Primary Care Doctor, Rating of Care, Coordination of Care and Rating of Health Plan confirming our members' satisfaction with our health plan. The Child and Child with Chronic Conditions are further surveyed per state contract by Title 19 and Title 21. Additionally, with the carve-in of dental services, we will also conduct an Adult Dental CAHPS survey to comply with Section V.M.13 of the Scope of Work (SOW). CAHPS results are reviewed by the QAPIC and applicable subcommittees, with specific recommendations for performance improvement interventions or actions. Specific interventions and initiatives are outlined in our annual CAHPS Action Plan, which is monitored by the QAPIC, and include staff training, member outreach activities, and health literacy programs. For example, we implemented "Ask Me 3" and created checklists on our website to educate members and engage in care with their PCP. Examples of other initiatives designed to address member satisfaction feedback and results include:

- Checklists on our website to educate members and engage in care with their PCP.
- Pharmacy staff is available for instant messaging from Member Services for real-time support with member questions related to pharmacy issues to increase first call resolution
- Care Management outreach to members with SDOH needs as identified through systematic reporting and analysis and/or Member Services or another source of referral, such as the member's PCP, LTSS case manager
- New Member Journey messaging to members to share information related to Medicaid benefits and resources phased over a three-month time frame
- The establishment of our Nebraska Member Care Compass Workgroup is designed to coordinate all member engagement activities and messaging across functional departments to avoid member abrasion and ensure a more seamless member experience. Additionally, it ensures that member-facing staff is prepared to answer any questions on distributed materials.
- Sharing of member messaging being provided to internal staff to ensure awareness and expedited call resolution to questions.

Behavioral Health ECHO Survey. In addition to Adult and Child annual CAHPS surveys, Nebraska Total Care conducts a Behavioral Health Experience of Care and Health Outcomes (ECHO®) Survey using an NCQA-certified external party. This survey is an NCQA requirement and best practice that evaluates a member's experience with behavioral health (BH) care and services. Results of the Behavioral Health ECHO survey are reported through QAPIC, BH, PIC, and MAC committees. We conducted this survey in 2020 and 2021. In 2021, because of increasing member exposure to BH treatment information from Nebraska Total Care and other related initiatives, an increased improvement was seen in the rating of counseling or treatment (12.1%) in Child and (4.5%) in the Adult ECHO surveys from 2020 to 2021.

Care Management Satisfaction Surveys. Additionally, we conduct a Care Management program survey on an annual basis to assess satisfaction and request feedback. We survey all members who are enrolled in care management and use responses to identify opportunities to make programmatic improvements and to contact members directly to address any concerns or challenges they include in their responses. Our Population Health team compiles responses and reports an analysis of survey results to the QAPIC to identify opportunities to improve the Care Management Program. For example, information gathered from our 2020 Care Management Satisfaction survey identified opportunities for improvement in terms of how members ranked their overall health after working with their care manager. In response, in 2021 we enhanced our Care Management staff training curriculum to include modules on Person-Centered Thinking and Motivational Interviewing as additional tools to help our staff to discover what is important to the member and better identify the strengths, and capacities, preferences, needs and desired outcomes of the member. Since implementing this new training module, we have found that our staff feels better equipped to help members to make their own informed decisions, develop personally defined outcomes, and set their own goals to achieve the life/outcomes they choose. In

Measurement Year 2020, 98% of respondents indicated they were satisfied with the help they are receiving or have received from their Care Manager.

Identifying Systemic Issues and Making Programmatic Improvements

Based on trends and issues identified from our member satisfaction surveys using the methods described above, Nebraska Total Care makes quality improvements to address member issues and concerns. Below are examples of how we have used member survey results to implement quality improvement programs and improved outcomes.

Member Survey Results/Findings.

- Member touch points and messaging by multiple Nebraska Total Care Departments
  Quality Improvement Intervention: We developed Member Care Compass, a coordinated, multi-faceted member engagement strategy to optimize our outreach efforts. As a result of this initiative, in 2020 we implemented our Member Care Compass Workgroup consisting of representatives from member-facing departments (e.g., Member Services, Population Health, Care Management, Quality, and Utilization Management) to ensure all member engagement activities and programs are coordinated and seamless for the member. The Committee meets monthly to review upcoming member engagement initiatives and messaging to further calibrate when and what volume is sent out to optimize member engagement and effectiveness.

  Improved Outcomes: As a result of our ***2020 Member Care Compass initiative, Nebraska Total Care had an*** NCQA Member Experience Rating score of 5 (1-5 rating) in MY2021 – used in the overall health plan rating.
- Opportunity for improvement in how members rank their overall health after working with their care manager in the 2020 Care Management Survey
  Quality Improvement Intervention: Implementation of Ask Me 3; Enhanced Care Management staff training on person-centered planning, trauma-informed care, and motivational interviewing.
  Improved Outcomes: In the 2020 Care Management Survey members rated their overall health before Case Management and after Case Management revealing an overall improvement of 28%.

71. Discuss the Bidder's experience with submitting HEDIS measures. Indicate whether the measures were reported for a State Medicaid, CHIP, dental, or commercial product line.
Page Limit: 1

Nebraska Medicaid Experience Submitting HEDIS Measures

Nebraska Total Care strives to provide quality health care to our membership as measured through HEDIS® quality metrics. We have direct experience submitting, reporting, and improving NCQA HEDIS quality measures for the Nebraska Medicaid and CHIP population since 2017. With over five years of experience operating in the Nebraska Medicaid and CHIP programs, ***we achieved a four-star health plan rating from NCQA Health Plan Accreditation in the first year of reporting HEDIS results*** in the measurement year 2020.

HEDIS Quality Infrastructure. Our well-established Quality Improvement (QI) infrastructure provides accountability and oversight for quality and health equity and is supported by our Board of Directors, quality committees and subcommittees, quality and analytics staff, and quality reporting and analytics. Our Performance Improvement Team reviews all quality results, including HEDIS and addresses performance deficiencies, with policy and intervention recommendations and appropriate follow-up. Targeted HEDIS Measure workgroups further analyze HEDIS data, review established best practices, and initiate and measure strategies and interventions to improve HEDIS measure rates. Data on quality improvement measures and surveys are further shared throughout the Quality Improvement Committee structure to educate and obtain feedback from key stakeholders including Nebraska Total Care teams, external providers, members, and key stakeholders. All committee reports and subcommittee discussions are shared within the QAPIC structure for discussion and approval of interventions and action plans.

Accountable Staff. Oversight of performance reporting and QI activities, including HEDIS submission, is provided by our Chief Medical Officer, supported by the Quality Management Coordinator and Maternal and Child Health/EPSDT Coordinator for daily operations. Our team consisting of our HEDIS Project Manager, Quality Practice Advisors, Quality Improvement Coordinators, Senior Health Equity Specialist, and a Quality Data Analyst regularly monitors outcomes and executes projects, in partnership with our providers, subcontractors, and other internal and external stakeholders. Responsible for data collection and HEDIS reporting is a HEDIS team that synthesizes data and creates calls to action, such as monthly care gap reports for member outreach.

Reporting and Analytics. We heavily invest in technology solutions to enhance our capabilities and facilitate provider coordination, collaboration, support, and oversight. We report monthly, quarterly, and yearly HEDIS data. Information is monitored and displayed through action-oriented ***HEDIS Dashboards*** (Question V.T. 111), reporting on baseline data, trends, goals by measure, and other filters. We ensure a health equity lens by filtering quality data and HEDIS measures by demographics, including race, ethnicity, language, and geography, and displaying HEDIS disparities and trends through our ***Health Equity Dashboard,*** as illustrated in our response to Question V.M. 73. QM and health equity information are shared across departments and with our providers to inform and prioritize interventions for continuous HEDIS measurement improvement.

HEDIS Software. As a component of Centelligence, we build, tabulate, and produce HEDIS measures using NCQA-certified software and quality tools to calculate HEDIS rates for regulatory reporting. We follow NCQA requirements for annual audits through Attest led by an NCQA-Certified HEDIS Compliance Auditor. We submit outcomes to NCQA for reporting in Quality Compass® for comparison against state and national health plans and regional and national benchmarks.

National Experience. In addition to our local Nebraska experience, our parent company, Centene, has over two decades of experience successfully submitting HEDIS measures across government-sponsored lines of business. For example, on a national basis, 29 Medicaid markets report HEDIS data; 32 markets report Medicare Advantage HEDIS rates; 31 markets report D-SNP HEDIS measures; 21 markets report marketplace HEDIS measures and 17 markets report the ADV HEDIS measure for at least one Medicaid submission. As a locally-based plan, we can leverage the resources and experience of our parent company and affiliate health plans to identify best practices from other markets for potential adoption in Nebraska.

72. Provide the Bidder's vision for the Bidder's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met.

Page Limit: 2

Established and Effective Nebraska Total Care Clinical Advisory Committee

Nebraska Total Care established our Clinical Advisory Committee (CAC) in 2017. Our Chief Medical Officer (CMO), Dr. Chris Elliott, is the chair of the CAC which reports up to the QAPIC. The role of this committee is to ensure best practices in clinical care, consistency in treatment standards across the network, and availability of clinical resources for network providers, including evaluation of strategies to guide clinical practices in the reduction of health disparities. The committee included network providers to engage the clinical experts at work across Nebraska. The CAC is committed to being part of the solution to improve health outcomes for children, older adults, members of all racial, ethnic, cultural, geographical, age, economic, linguistic, religious, sex, gender, and disability communities, and various clinical conditions.

CAC Purpose and Goals

The purpose of the CAC is to facilitate regular consultation with practitioners familiar with standards and practices of treatment for medical, behavioral health (BH), and dental health (planned) service delivery. The committee solicits input into all policies, procedures, and practices associated with Case Management and Utilization Management (UM) functions, including:

- Review, discuss, and recommendations on Clinical Practice Guidelines and UM Criteria, to ensure they reflect current standards consistent with research, evidence-based practices, and community practice standards
- Approval and adoption of Clinical Practice Guidelines and UM Criteria that are reflective of the standard of evidence-based practice and administrative state code
- Identification of key issues and gaps in care that may affect specific community groups
- Input on proposed Nebraska Total Care service improvements
- Offering effective approaches for reaching or communicating with providers and members on issues related to Nebraska Total Care's member population
- Evaluation of health disparity data and Nebraska Total Care's health equity action planning

Meeting Frequency and Minutes

The Nebraska Total Care CAC meets quarterly. Meeting materials are distributed securely to committee members before the scheduled meeting date with sufficient time to provide a review of these materials, as applicable. Draft minutes are completed within 30 days of the meeting, reviewed by the chair, finalized at least 10 days before the next meeting, or as needed for regulatory reporting, and submitted to QM for review by the QAPIC. Minutes are provided to MLTC for review and additional discussion and recommendation as appropriate.

Committee Composition

The CAC includes representatives serving children, adolescents, and adults across the state in rural, urban, and frontier areas and representing a variety of races and ethnicities reflective of the population, including pharmacy, Public Health, and BH. All of our quality sub-committees include representation from the Health Equity and Diversity Committee; on the CAC this is the Vice President of Population and QM Coordinator who co-chair the Health Equity and Diversity Committee. With the inclusion of dental services in the new program, the CAC will be expanded to include dental content and dental providers. Nebraska Total Care staff participants include:

- Chief Medical Officer (Chair)
- Director, Clinical Operations
- Vice President, Population Health
- Manager, Utilization Management
- Director, Quality Improvement
- Quality Improvement Coordinator
- Medical Director, Behavioral Health
- Dental Director (planned, recruitment in the process)

Current external committee representatives include:

Name	Title
Amy Arndt, DNP, APRN-NP, FNP-C	Family Nurse Practitioner, Hart Family Health
Amy McMurtry, PharmD	Clinical Pharmacy Manager, Nebraska Medicine
Christine Eisenhauer, PhD, APRN-CNS	Assistant Professor, Clinical Nurse Specialist - Public Health – University of Nebraska Medical Center
Courtney Allen Cowardin, CNM	Associate Medical Director Women's Health Services - One World FQHC

Name	Title
Tina Vest, APRN, CNP	Vest Psychiatric Services, LLC
Traci Jenkins, Nurse Practitioner	Macy, NE

Improving Care and Services through CAC Input

The CAC is a consistent source for collecting provider feedback. Following are examples of questions and suggestions from the CAC and the subsequent follow-up action.

CAC identified needs	Nebraska Total Care Action and Outcomes
Increase in need for mental health services as a result of the pandemic.	Enhanced provider education to support the use of telehealth to provide BH services, and additional outreach to support agencies, including Public Health and Indian Health Services. From 2020 to 2021, BH Providers increased telehealth utilization by 8.3% at the Provider Group level and by 11.4% at the individual practice level.
Absence of resources for serving LGBTQIA+ individuals	Recommendations made by the committee led to the national adoption of Behavioral Health Clinical Practice Guideline for Gender Reassignment and Transgender Issues and provider training entitled Providing Services to LGBTQIA+ Populations offered in 2021. An updated version developed by the Clinical Provider training team was released in April 2022 with the updated title: Cultural Competent Care and the LGBTQIA+ Community. Since developing the training, we have trained 18 providers over four offerings in 2021 and have trained 11 providers over two offerings so far in 2022.
Difficulty locating the state consent form	Link added to the Nebraska Total Care website, which averages 30,000 provider visits monthly.
The gap in care for youth transitioning out of foster care	Process improvement implemented: • Accessing State foster care reporting, the Foster Care Liaison identifies youth who are 6 months away from turning 19. • Direct outreach to the assigned Child and Family Services Specialist with education on the process to maintain Medicaid benefits up to age 26. • Offer Case Management services working directly with the youth to transition Medicaid, health care, and other services into adulthood. • Implementation of the adolescent to Adulthood (a2A) educational program with our members and community-based organizations.
High rate of BH hospitalization for children in foster care, need for aftercare	Process improvement (in the process): • Development of the Foster Care Dashboard to isolate data such as location and provider for increased analysis and action planning. • BH telehealth services through Brave Health with a value-based relationship around follow-up after hospitalization. • DHHS access to our secure community partner portal for simplified communication and coordination strategies.

73. Discuss the Bidder's vision and any experience with a health equity committee. Describe how the requirements of the RFP will be met.

Page Limit: 2

Our Health Equity Committee Vision

Our Health Equity and Diversity Committee (HEDC) is part of a concerted effort to enhance our health equity improvement strategy, vision, and goal. This includes people, systems, processes, and activities designed to reduce disparities, address social risk factors, and achieve health equity across the state of Nebraska. Already designed to meet the requirements of the RFP, as outlined in Section V.M.5, the purpose of the HEDC is to improve health outcomes through data-driven initiatives across all plan functions. The council is charged with identifying areas of disparity and collaborating with members, providers, and communities to develop policy and innovative care strategies that proactively address cultural and social needs and promote the elimination of health disparities. At least one representative from the HEDC sits on all of our quality sub-committees. Reporting to the QAPIC, the HEDC responsibilities include:

- Implementing our Health Equity Improvement Model
- Acting as an ally for groups experiencing health disparities in Nebraska
- Supporting community-based organizations that work with populations experiencing health disparities
- Implementing evidence-based and community-driven quality and performance improvement practices
- Identifying health disparity reduction opportunities and establishing enterprise priorities for health equity
- Reviewing, approving, and supporting Nebraska Total Care's Health Equity Workplan
- Assisting with and supporting health equity workgroups and deliverables
- Evaluating and developing recommendations for Nebraska Total Care health disparity training needs
- Partnering with community-led organizations to promote culturally relevant and SDOH-related programs

Meeting Frequency, Minutes, and Committee Composition. The HEDC typically meets monthly, but no less than quarterly, with additional meetings scheduled as needed. Written meeting minutes are maintained and submitted to QAPIC and MLTC for review and recommendation as appropriate. Committee chairs include the QM Coordinator and the VP of Population Health with department representation from across functional areas, including:

- Population Health/Clinical Operations
- Utilization Management
- Government Relations
- Provider Relations/Contracting
- Quality
- Grievance and Appeals
- Human Resources
- Compliance
- Tribal Liaison
- Member Services
- Vendor Management
- Pharmacy
- Member and Community Engagement
- Medical Directors (CMO, Dental, BH)

With the foundational committee structure established, the committee is currently recruiting external stakeholder representative of the communities we serve, including:

- Members and member representatives from various racial, ethnic, and language backgrounds and geographies and including members with disabilities and who are dually eligible for Medicare and Medicaid
- Medical, dental, and BH providers from across disciplines and geographies
- Community leaders working with under-served populations

To help promote and facilitate greater participation, we directly outreach and provide personal invites, leverage community partners to identify and approach prospective committee members, hold meetings at convenient times and locations (including virtually), provide disability accommodations, and provide transportation for members and member representatives.

Delivering on Health Equity Goals. To meet the requirements of the RFP, align with MLTC quality strategy goals, and have a positive impact on health equity, we have deliberate programs and processes to support the HEDC, plan staff, providers, and communities in improving health equity. Key to this function is our Health Equity Improvement Model (Figure 73.A) which applies a four-step process for identifying and addressing health disparities and SDOH needs. This information informs community strategies, such as our Health Equity Neighborhoods. Health Equity Neighborhoods is a Centene-developed national best practice for identifying and addressing disparities through hyper-focused community-wide engagement, learning from Robert Wood Johnson Foundation and other public health models, fully described in Question 114. Feeding the HEDC will be Neighborhood Councils inclusive of community-based organizations, members, providers, local government agencies, and other stakeholders convened in each Health Equity Neighborhood. Our goal is to create a forum that elevates the member voice through a participatory process to develop local action plans in their community for their community.

Figure 73.A Summary of the Health Equity Improvement Model

We start by ***dissecting and analyzing data*** related to utilization and outcomes, using integrated quantitative and qualitative data from over 200 data points to identify health disparities in our member population. Using national best practices and the experience of local partners, we ***identify potential solutions*** at the member, provider, and community levels. Working in collaboration with invested strategic partners, we ***enhance existing and design new initiatives*** we collectively agree are likely to impact equity outcomes. Included in the design strategy are ***SMART goals with established timelines*** for evaluation, modification, and expansion as we are able.

SDOH Framework. Recognizing the direct impact of SDOH on health disparities, our improvement model fully integrates with our SDOH strategy. We use heat maps that identify social predictors correlated with poor health outcomes. We overlay our health equity and SDOH data to identify correlation, then working with our community partners, we further evaluate to determine causation. Identifying these geographic "hotspots," allows us to drive holistic population health goals and reduce disparities. We then tailor local solutions in direct collaboration with the community for the community.

Health Equity Tools. To assess the impact of SDOH and other disparities on HEDIS quality outcomes, we will use our ***Health Equity Dashboard***. The dashboard displays performance across HEDIS measures by demographics such as race, ethnicity, age, and geography. Separate displays are available for each MLTC product line allowing us, for example, to compare D-SNP and non-D-SNP members with otherwise similar demographics. The tool offers multiple displays with "geo maps," tables, and bar charts to easily recognize health disparities and changes over time, including SDOH overlays as described above and made available through our ***predictive analytics tool, social need assessments, and provider reports***. Our ***SDOH KPI Dashboard*** aggregates SDOH data to analyze SDOH needs by location and demographics to support the implementation and evaluation of our SDOH and health equity initiatives. Our HEDC, with the future inclusion of providers, members, and community partners, directs the utilization of all of the combined data toward impactful interventions.

Our Health Equity and Diversity Committee Experience

Our current heath equity initiative focuses on removing disparities around birth outcomes and includes:

Table 73.A Health Equity and Birth Outcomes

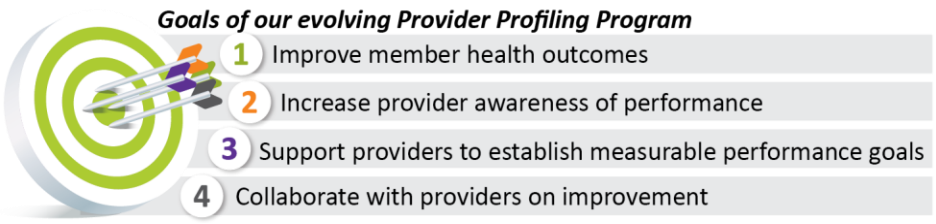
Initiative Focus	Outcome
Analysis	Our data shows higher rates of NICU admissions in three specific Douglas County zip codes 68111, 68104, and 68110.
Best Practices	Overall, our affiliate found that members paired with a doula had 27% higher postpartum care visit rates compared to enrollees without doulas. Based on successful affiliate experience addressing significant disparities in their Black members' maternal outcomes through a doula project, we have identified doulas as a key strategy in our maternal and child health program.
Design Initiatives	We are currently in the implementation phase. At present we are working with local doula organizations, provider partners, and national resources to design a doula pilot for Nebraska.
Implement and Evaluate	We have committed to covering doula services for 100 members in the identified underserved neighborhoods, with implementation Fall 2022. As a part of the design process, we are including close communication with all partners to monitor outcomes and establish protocols that can be replicated and expanded to additional areas of disparity.

74. Describe the Bidder's practice of profiling the quality of care delivered by PCPs, specialists, and hospitals, including the methodology for determining which and how many providers will be profiled.
- *Submit sample quality reports.*
- *Describe the rationale for the selection of measures that are collected and reported.*
- *Describe the proposed frequency for these profiling activities.*

Page Limit: 3 Excluding sample quality reports

Provider Quality of Care Profiling Program

Provider reporting and profiling is a key factor in identifying, addressing, and evaluating the quality of care (QOC) delivered by our network providers, including PCPs, specialists, and hospitals. We have local and national experience in provider profiling, which we use to inform our quality activities and support providers in improving their delivery of care and services. With a model of continuous quality improvement, we are evolving and enhancing our provider profiling program.



Our current provider profiling activities are largely at the group level and inform our Joint Operating Committee (JOC) meetings and support providers in improving success under value-based purchasing (VBP) arrangements. Developed from national best practices, our provider profiling policies are being updated at the local level to meet MLTC goals and objectives, monitor and inform individual provider performance, and include processes and guidance for:

- Selecting profile indicators
- Analyzing provider historic claims/encounters, lab, immunization, pharmacy, and outcomes data
- Communicating profiling results to providers
- Helping providers use feedback to improve care and member outcomes
- Offering financial and non-financial provider incentives to encourage continuous improvement

Provider Types Profiled. Building on practice-level and group reporting and profiling, our provider profiling will extend to Primary Care Providers (PCPs) and Specialists, including BH and dental providers to engage all providers in achieving our common goals. We will also include provider profiling specific to providers serving members in both Medicare and Medicaid through our HIDE SNP.

Areas of Performance Measurement. To meet our objectives, we effectively track, measure, and report on provider performance related to key priorities, such as primary care access, preventative care, and chronic disease management. ***Priority areas are selected based on annual quality priorities as documented in the annual quality work plan, as well as in alignment with the MLTC quality strategy, EQRO audit results, and direct member and provider feedback and needs.*** Examples of proposed individual performance measures include:

- HEDIS measures in alignment with QPP state performance measures
- Closed member care gaps
- Members are seen by their PCP annually
- Experience survey data at the individual provider level
- Members on psychotropics with BH provider visit
- Readmission rates by hospital
- ED utilization

Frequency of Provider Profiling. With various goals and objectives, provider profiling activities are ongoing. We meet with our value-based purchasing (VBP) partners, representing over 60% of our membership, monthly, reviewing provider analytics and reports that highlight performance and call out opportunities for improvement. We also produce quarterly profiles in advance of our quarterly Joint Operating Committee (JOC) meetings with our VBP groups. Other reporting is done on a daily, weekly, monthly, quarterly, and annual basis to consistently evaluate the QOC delivered by providers and intervene as indicated. Individual provider profiling will be at least annually.

Tools Used to Generate Provider Profiles. To ensure that our profiling process is comprehensive, we utilize many data sources and analytic tools. A component of Centelligence is our use of industry-leading and National Committee for Quality Assurance *(*NCQA) certified quality tools. We produce provider-level, risk-adjusted profile reports from Centelligence, which captures data from internal and external sources to produce actionable information for providers. Profile results will include individual provider performance and be risk-adjusted for meaningful peer-to-peer comparison. Specific tools used

to support these activities are further described in **Table 74.A** below.

Table 74.A Technologies and Programs to Support Meaningful Measurement and Provider Profiling	
Value-based purchasing (VBP)	We use provider profiling to support providers in achieving quality goals outlined in their value-based contracting arrangements. The information available to providers includes specific VBP metrics, actionable data to improve outcomes, and progress toward VBP goals.
Reports	We regularly measure provider performance through review of utilization data, HEDIS, and claims reports and share information with providers during JOC meetings.
Analytics	Providers can track their performance through our provider analytics dashboard tool, available through our secure Provider Portal, where they can find insight into provider peer group comparisons, cost and utilization trending, and quality measure performance.
Additional Activities	Additional activities include reviewing compliance rates, satisfaction survey results, onsite surveys and medical record audit results, and PCP transfer request rates. We will also educate providers on the Findhelp Community Resource Platform that is used to identify local resources available to our members, connect members to services, and track the provision of services through closed-loop referrals, which we can report on to evaluate the impact of SDOH supports.

Provider Profiling Benchmarks. Annually, the QAPIC and Provider Advisory Committee (PAC) help establish performance thresholds and improvement benchmarks for performance measures. The Committees derive benchmarks from network-wide data, NCQA standards, and utilization criteria, among other credible data. Each indicator must be measurable, reliable, and valid; have reliable benchmark data; be relevant to our members, providers, and our QAPI program; and be actionable by providers. We will use the same indicators for multiple years to establish trends, and assess improvement over time, aiming to improve year-over-year outcomes. Individual provider profile reports will have unique sets of indicators, relevant to the services rendered by providers, and promote compliance with clinical practice guidelines. We currently communicate metrics, goals, and benchmarks to our providers through our Provider Newsletter, secure Provider Portal, and education.

Intervention Activities to Improve Provider Performance. As part of the monitoring, reporting, and profiling process, we have procedures to quickly and appropriately respond to issues. For example, Provider Relations Representatives schedule in-person meetings with the provider and a clinical designee, for example, Medical Director or QI Coordinator, to discuss performance issues, identify barriers, and develop an improvement work plan or corrective action plan (CAP), if needed. Ongoing monitoring and education are performed until performance improves. If a provider's performance does not improve upon intervention, the QAPIC may impose appropriate disciplinary actions, up to contract termination. Additionally, to incentivize positive performance, we find examples of outstanding provider performance when performing profile activities and recognize those providers in one of several ways. For example, we offer a yearly award to a top-performing provider, outreach to our high performers to identify best practices and share across the network, and may reward providers meeting quality benchmarks by offering enhanced member assignments for members that have not chosen a provider or waived prior authorization, for pre-defined services.

Performance Improvement Resulting from Provider Profiling. Nebraska Total Care actively works with our VBP partners in improving quality and member outcomes. SERPA, an ACO VBP partner, invited our team to present clinic-specific report cards related to quality and risk adjustment performance along with quality resources in the Summer of 2021. Report cards and performance were shared among all clinics which generated idea sharing on how to improve measures metrics. SERPA continues to build upon those discussions and show improvement. Examples of data and reporting shared with our VBP partners to support their member outreach and engagement and quality improvement initiatives include:

Table 74.B Provider Reports

	Report Name	Frequency	Description
	Discharge Census	Daily	Identifies members who have been discharded from the hospital in the past 30 days and require follow up care. Includes discharge date, diagnosis, and facility name.
	Inpatient Census	Daily	Lists members who are currently in the hospital. Includes facility name, admit date, and diagnosis.

	Report Name	Frequency	Description
	Captiation File	Monthly	Contains aggregated capitation payment data, which is organized into capitation categories of the financial statement.
	Detailed Claims File	Monthly	Consists of medical and pharmacy claims data, which ties directly to expenses on the Financial Statement. Reflects claims included in MLR calculation and allows for analysis.
	Financial Statement	Monthly	Includes three product summaries broken out by total dollars, PMPM and PCP. Provides uear-to-date summary.
	Eligibility Criteria	Monthly	Outlines performance against the eligibility requirements. Identifies the members needing a sick or well visit with their primary care provider by the end of the year.
	Member Panel	Monthly	Identifies assigned members. Includes contact information, date of last PCP visit, and revenue that ties to the Financial Statement.
	Utilization Report	Monthly	Shows a snapshot of key metrics to display trends in utilization. Assists with prioritizing member outreach and engagement.

Sample Provider Quality Reports

Sample provider reports are included in **Attachment B.74 Sample Provider Reports.**

75. How will the Bidder use the Member Advisory Committee to improve quality of care and direct quality and operational changes? What representation does the Bidder plan to have on each committee (e.g., stakeholder types, from what geographic areas)? How will the Bidder identify participants of the Member Advisory Committees?
Provide examples from other states where the Bidder has collaborated with members for program improvement.
Page Limit: 5

Nebraska Total Care Member Advisory Committee

Member involvement is critical to establishing meaningful programs that support individual health goals. The Member Advisory Committee (MAC) is one strategy for soliciting formalized input on our processes, materials, and services, and engaging members in action planning. As the most impacted but often least heard stakeholder in the health system, the MAC provides members a forum entirely focused on their needs and experiences. The committee is chaired by our Member Services Manager, Dee Kohler, who is also a member of our Health Equity and Diversity Committee (HEDC).

We convene MAC meetings quarterly, at a minimum. Constraints around COVID-19 risk and vaccination status make ensuring the safety of participants our highest priority, and at present, the meetings remain virtual. Members can participate online or by phone. Meeting materials are void of PHI or proprietary information, so are mailed to members ahead of the meeting. The MAC reports and is accountable to the Nebraska Total Care QAPIC, and the committee-approved minutes are shared with the QAPIC and MLTC for review and recommendation. as appropriate. Additionally, the MAC is directly connected to the HEDC for engagement in disparity reduction activities. The MAC aligns with the Scope of Work (SOW) Section V.M.6, while also allowing for member-directed content and discussion.

The MAC engages departments as necessary to meet participant requests for education and planning. In 2021, the following departments participated in MAC meetings based on agenda items and member requests:

- Utilization Management
- Care Management
- Member Services
- Behavioral Health
- Marketing/Communications
- Pharmacy
- Quality Management
- Compliance

Soliciting MAC Feedback to Drive Program Development, Design, and Improvement

To support our QAPI Program and Annual Work Plan, we develop an Annual MAC Plan, which outlines the committee participants, annual meeting cadence and dates, and priority agenda topics. The MAC plan is submitted to MLTC for approval annually before implementation. The following table describes our 2022 priority agenda topics.

Table 75.A 2022 Annual MAC Plan

All Meetings:

1. Review of committee purpose and the role of members
2. Review of HIPAA standards related to participation
3. Opportunity for open discussion related to member experience, needs, and concerns
4. Updates and/or training on a Nebraska Total Care program
5. Opportunities to discuss potential barriers to care

Quarter 1	Quarter 2	Quarter 3	Quarter 4
1. Member Orientation a. Medicaid 101 b. Nebraska Total Care Organization Structure 2. Review Annual Health Checklist 3. 2022 Member Communication/ Education Plan 4. Member Newsletter plan for 2022	1. Member Orientation a. Quality Improvement Program and Process b. Heritage Health contract requirements 2. Fluvention Program Update 3. Case Management Overview	1. Review of Annual Member Notification Mailing 2. Overview of Nebraska Total Care HEDIS goals 3. Culturally & Linguistically Appropriate Services Goals 4. Nebraska Total Care OTC program	1. Proposed plan changes and Value-Added Services for 2023 2. Review charter for 2023 updates 3. Results of 2022 CAHPS Survey and action plan 4. Community engagement strategy

Additional topics for discussion:

1. New member educational materials
2. Changes to the Member Handbook
3. Introduction of new programs and resources
4. Education on services available to members
5. Changes to policy or procedures impacting members
6. Any additional topic impacting members or that could be improved with member feedback
7. Grievance trends for evaluation and recommendation

Engaging MAC Participants

Nebraska Total Care has extensive experience engaging stakeholders through our quality and advisory committees. Participating in the MAC gives impacted stakeholders a voice in program development, implementation, improvement, and ongoing operations. MAC membership is continually open, allowing members to join the MAC at any time. Specific strategies for engaging participants include:

- Consulting with stakeholders, including providers, MLTC staff, community-based organizations, and advocacy groups to help identify potential member participants
- Providing an electronic signup form on the Nebraska Total Care member website allows members to indicate their interest in joining the MAC. Following completion, the committee chair contacts the member for engagement.
- Sending information on the MAC to all members annually by mail and email.
- Supporting consistent processes for planning. All quarterly meetings are established at the beginning of the year.
  - Two weeks before each meeting, members are sent an email reminder with materials attached
  - One week before the meeting, physical agendas and materials are sent to the members
  - Two days before the meeting, all members receive a follow-up call to confirm attendance
- Offering multiple avenues for virtual participation.
- Engaging members from across the state (e.g. rural, urban, frontier, and tribal areas), across populations (e.g. foster care, members with disabilities, and dual eligible members), and various races and ethnicities to ensure representation from diverse groups
- Allowing for the participation of member advocate professionals in addition to, but not in replace of, members
- Incorporating activities to blend education with social support building.

Ensuring MAC Diversity and Representation. Nebraska Total Care ensures the composition of our MAC is diverse while still being manageable and productive. As we do with staff recruitment, we employ recruitment strategies that attract participants who match the demographic and diversity of our population. For example, advertising for Council participation through our social media channels, including Facebook, Twitter, and LinkedIn, and through face-to-face contact and community events. MAC membership includes members, families, and other key stakeholders. Members are encouraged to invite a member of their support system, including their Nebraska Total Care Care Manager if that allows them to more comfortably participate. Current participants include 14 Nebraska Total Care members and representatives from Aging Partners, Public Health Association of Nebraska, Public Health Nurses, Chair of NE Statewide Independent Living Council, a Nurse with Encore, and a Public Health Nurse with the North Central Department of Health. Our goal is to achieve at least 51% member representation.

Key requirements for participation in the MAC include candidates who:

- Promote diversity, equity, and inclusion, especially health equity
- Embrace an integrated approach to helping to improve the health and wellbeing of Medicaid populations
- Support a person- and family-centered, strengths-based, trauma-informed approach
- Understand the challenges facing Medicaid, dual eligible, and CHIP members

As an extension of our Member Advisory Committee, members serve on a variety of other quality and advisory committees. For example:

Tribal Healthcare Advisory Committee. Our Tribal Healthcare Advisory Committee includes representatives from each of the Tribes and tribal communities to promote meaningful communication and input to assist us in providing culturally effective services and care management approaches for the American Indian population.

HIDE SNP Member Advisory Committee. Supporting our members who are dually eligible for Medicare and Medicaid, we are creating a HIDE SNP MAC to ensure focused input from members in our HIDE SNP.

Dental QAPIC. As part of our new Dental QAPIC, we will invite members to participate and share insights into community dental health needs, access concerns, and quality of dental services. Through direct member participation, we can build a dental benefit program for members with members.

Health Equity Neighborhood Councils. Our parent organization, Centene, is a pioneer in health equity programming. As a national best practice, Nebraska Total Care will invest in Health Equity Neighborhoods in high-need Nebraska counties. Using an anchor community entity, such as United Way and/or an established neighborhood organization, we will support neighborhood councils and community development activities. With the anchor organizations, we will support health equity research on local lived experience and needs, and partner on SDOH interventions and funding. In direct partnership with community leaders, recognizing their expertise, lived experience, and the relationships and innovations that already exist, we will convene community-based organizations, members, providers, local government agencies, and other stakeholders to create a new or support an existing Neighborhood Council. The goal is a forum that elevates the member voice through a participatory process to develop local action plans. Our Health Equity Neighborhoods are described in detail in response to Question 114.

Examples of Member Collaboration to Promote Improvement

During the Nebraska Total Care MAC meeting on April 22, 2022, many committee members shared their concerns about the transportation company not approving rides to COVID-19 vaccination clinics that were not health care sites, such as churches or community centers providing vaccinations. In less than two days, the concern was raised with leadership and an approval process was completed with the transportation vendor to assure all Nebraska Total Care members received free rides to and from vaccination clinics, regardless of site.

Nebraska Total Care uses POM calls to remind members of gaps in preventive care. In review of the annual Member Education Plan, the Committee discussed effective use of these calls. They recommended scheduling the calls during the day, both to avoid family time in the evenings and allow member to contact Member Services and Provider offices during business hours following the call. Following the meeting POM strategy was altered and calls were reprogrammed as recommended by the MAC.

> "Nebraska Total Care covers the extra services I need that other plans don't cover. I've never had any negative experiences with them and I highly recommend people go with Nebraska Total Care."
>
> *- Carla, Nebraska Total Care member and MAC participant*

76. Describe the information the Bidder will provide to members and providers about the QAPI program, and how this will be achieved

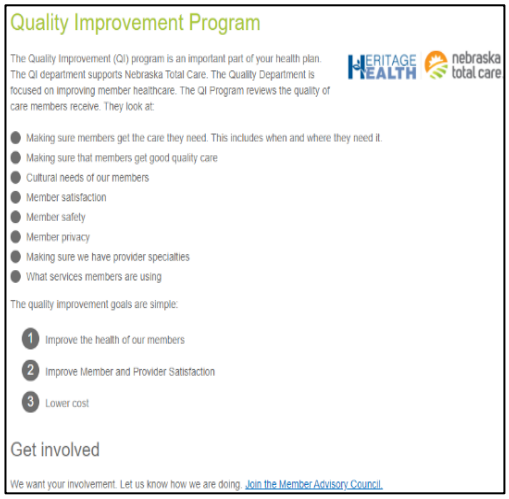
Page Limit: 2

Informing Members and Providers about the QAPI Program

As described throughout this response, Nebraska Total Care actively engages members and providers in our quality activities. We rely on their input to inform our quality strategies and share quality information to assist in improving health outcomes. Information sharing is bi-directional and leverages forums such as our Advisory and other Quality Committees, Web Portals, and Newsletters.

Information Shared with Members. Across the membership, members can access a copy of our QAPI program description on our public website (**Figure 76.A**). We present our QAPI Program annually to the Member Advisory Committee (MAC) to highlight quality goals and objectives and demonstrate how quality is measured, promoting accountability, and providing an opportunity for input. We also regularly publish quality outcomes data and promote quality campaigns through our quarterly Member Newsletter (**Figure 76.B**). For example, in advance of flu season, we include articles on the importance of getting a flu shot. HIDE SNP members are also informed of outcomes and evaluation of the Model of Care (MOC) as part of our annual D-SNP MOC education.

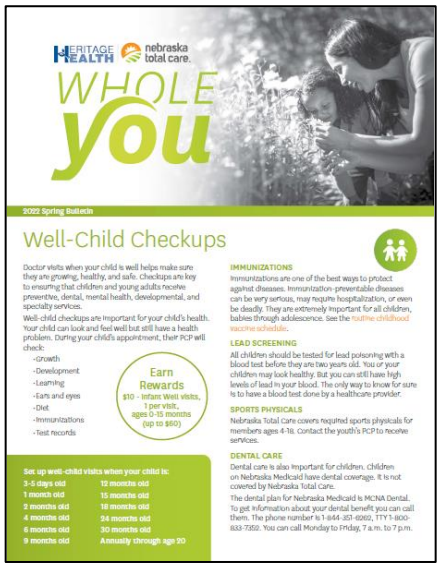
Figure 76.A



On an individual basis, members have access to their secure Member Portal account to view their clinical service and medication history and view health alerts. The Member Portal also allows members access to several other self-service functions, such as the ability to complete the Health Risk Screening and Notification of Pregnancy or view their member-centric plan of care. We guide accessing the Member Portal through our Member Care Compass program, our multi-faceted member engagement strategy which includes welcome materials, our member website, and directed outreach.

Information Shared with Providers. Providers are actively involved in our quality committee structure, with participation on our Board of Directors, QAPIC, Clinical Advisory Committee, Health Equity and Diversity Committee, Credentialing Committee, Utilization Management Committee, Joint Operations Committees, Pharmacy and Therapeutics (P&T) Committee, Peer Review Committee (ad hoc Committee), Behavioral Health Advisory Committee, Tribal Health Advisory Committee, and Provider Advisory Committee. Through this engagement, providers are informed about our QAPI Program, Annual Work Plan, Annual Evaluation, and ongoing quality activities. We also share information on our QAPI during Provider Orientation and regular visits with Provider Relations Representatives and related provider expectations are outlined in our Provider Agreements. Individual provider and group quality data are shared quarterly at Joint Operating Committee (JOC) meetings with our provider clinics and groups. Examples of quality data presented during JOCs include HEDIS performance, satisfaction survey results, under and over utilization, and grievance and appeals data. To further support providers in improving the quality of services, we share Clinical Practice Guidelines on our website and encourage provider use through outreach and education, including seasonal and relevant information published in our Provider Newsletters. Finally, providers have access to self-service quality information and reporting through our secure Provider Portal. Clinical applications available on the portal include online care gap notifications and health alerts, a member health record, Admission, Discharge, and Transfer (ADT) notifications, Patient Analytics, Provider Analytics, care, and disease management referral, and clinical practice guidelines.

Figure 76.B Member Newsletter



Patient Analytics Dashboard. We offer our Patient Analytics solution to enable practice managers or individual providers to access patient disease registries (at the PCP or practice level) to view critical information including evidence-based care gaps, and quality improvement opportunities, and improve their population management functions. Patient Analytics offers providers an integrated view of their patient's physical and BH diagnoses, in addition to medication, lab, and care team

data, on a member level. Patient Analytics allows providers to conduct population management, such as analyzing patients that need a flu shot vaccine and issuing reminders.

Provider Analytics Dashboard. We offer our Provider Analytics solution (**Figure 76.C**) on the Provider Portal to enable providers the ability to assess the cost and utilization trending, quality measure performance, disease prevalence, readmissions, and health trends. Providers are offered many of these metrics on a risk and severity-adjusted basis. Providers have access to custom selection, drill-down, and export capabilities to help identify performance trends. By using Provider Analytics, providers can monitor their performance versus contractual or bonus goals.

RFP 112209 O3

Attachment B.64

2022 QAPI Work Plan

KEY for 2022 Committee Planning Calendar By Quarter:

Column Header	Definition
Quarter *(timeframe reviewed)*	Suggested Quarter to take to the identified committee.
Committee	Name of Committee to approve the report or summary.
Report Name	Identifies the name of the report or summary to be presented.
Related NCQA Standard	Current NCQA standard that identifies the information for accreditation, if applicable.
Reporting Period	Identifies the reporting timeframe to be reflected in the report. "Annual" is defined by NCQA as a 12-month period, with a 2-month grace period.
Planned Date to Committee	Identify the projected date information is planned to take to committee.
Actual Date to Committee	Record actual date the information was taken to committee.

KEY for 2022 Work Plan Template:

Quality Work Plan is outlined by the Responsible Department. Within each Department Section, the required objectives and activities are listed for monitoing to completion each year.

Column Header	Definition
Requirement/ Authoritative Source	Identifies the source that requires this activity to be completed so that the details can be referenced, if applicable.
Scope	Identifies the primary area of work the activity covers.
Objective	Identifies the intent of the required activity. "Annual" is defined by NCQA as a 12-month period, with a 2-month grace period
Activity	Identifies the specific activity that must be completed. Insert a row below all applicable activities if State or CMS submission is required for specific documents.
Responsible Party	Department/Lead responsible for making sure the activity is completed.
Month/Year Completed Medicaid	MEDICAID line of business-note committee meeting date/details as applicable.
Month/Year Completed Marketplace	MARKETPLACE line of business-note committee meeting date/details as applicable.
Month/Year Completed Medicare	MEDICARE line of business-note committee meeting date/details as applicable.
Comments	Note items that require ongoing evaluation and and monitoring of previously identified issues.
Last Section *(at end of document)*	**Additional Quality Improvement Projects/Contractual Requirements**-this section is for summarizing/tracking overall status of projects, including contractual requirements that are health plan-specific-larger tracking tools may be used for specific project details.

KEY for 2022 Interventions:

Insert health plan-specific HEDIS/STARS/CAHPS project plan/improvement plan on this tab if you would like to keep all quality activities in one document.
Please make sure to designate a column that links your HEDIS interventions to the appropriate NCQA standard.

EXAMPLE: 2022 COMMITTEE PLANNING CALENDAR BY QUARTER - green font designates changes/clarifications made to the original current year versior

Quarter *(timeframe reviewed)*	Committee	Report Name	2022 Related Standard	Reporting Period	Planned Date to Committee	Actual Date to Committee
Q1	Quality Committee	Quality Program Description	QI 1A	Annual		
Q1	Quality Committee	Quality Work Plan	QI 1B	Annual		
Q1 *(prior year HEDIS report and/or prior CY data)*	Quality Committee	Quality Program Evaluation	QI 1C	Annual		
Q1	Quality Committee	Cultural Competency Plan		Annual		
Q1	Medical Management Committee	UM Program Description	UM 1A	Annual		
Q1 *(prior CY data)*	Medical Management Committee	UM Program Evaluation	UM 1B	Annual		
Q1 *(prior CY data)*	Medical Management Committee	UM Timeliness Report	UM 5D	Annual		
Q1	Quality Committee	Grievance, appeals, QOC and critical incidents (if applicable) summary report	Multiple Standards	Quarterly		
Q1	Quality Committee	Summary of credentialing activities (i.e. review/approproval of credentialing policies, annual delegate oversight audits, etc.)	CR 1	Annual		
Q1	Quality Committee	Overview of pharmacy program (e.g. Pharmacy Program Description/policies, annual summary of pharmacy activities,	UM 11	Annual		
Q1 *(prior six months data)*	Credentialing Committee	Monitoring Potential Practitioner Quality Concerns Report	CR 5A	Semiannual		
Q2 *(prior CY data)*	Quality Committee	Customer Services Telephone Access Report		Annual		
Q2	Quality Committee	Executive Summary of Program Descriptions *if originally approved at another committee* - CM Program Description - UM Program Description - LTSS CM Program Description, if applicable	Multiple Standards	Annual		
Q2	Quality Committee	PHM Strategy Description	PHM 1A	Annual		
Q2 *(prior CY data)*	Quality Committee	Population Assessment	PHM 2B-C	Annual		
Q2 *(prior CY data)*	Quality Committee	PHM Stratification/Segmentation Report	PHM 2D	Annual		
Q2 *(prior year HEDIS report and/or prior CY data)*	Quality Committee	PHM Effectiveness Analysis	PHM 6A	Annual		
Q2 *(prior CY data)*	Quality Committee	Overview of provider incentive models (e.g. NCQA Value Based Payment report/worksheet, P4P reporting, value-based reporting suite, etc.)	PHM 3B	Annual		
Q2 *(prior CY data)*	Medical Management Committee	Care management satisfaction/experience survey results	PHM 6A	Annual		
Q2	Medical Management Committee	Preventive & Clinical Practice Guidelines		Annual		

Q2	Medical Management Committee	Medical necessity criteria (e.g. clinical policies, InterQual, Medicare LCDs/NCDs, etc.) **criteria approved annually by Centene Clinical Policy Committee*	UM 2A	Annual		
Q2	Quality Committee	Policies and Procedures for Grievance & Appeals	Multiple Standards	Annual		
Q2	Quality Committee	Grievance, appeals, QOC and critical incidents (if applicable) summary report	Multiple Standards	Quarterly		
Q3 *(prior CY data)*	Quality Committee	Email Response Analysis Report	ME 6D	Annual		
Q3	Quality Committee	Customer Service Telephone Access Report				
Q3 *(prior CY data)*	Quality Committee	Quality & Accuracy of Member Benefit Information Report	ME 6C	Annual		
Q3 *(prior CY data)*	Quality Committee	Quality & Accuracy of Pharmacy Benefit Information Report	ME 5C	Annual		
Q3	Quality Committee	Present outcome measures, CAHPS/QHP survey results and action plan to Quality Committee	NCQA ME 7	Annual		
Q3	Quality Committee	Present HOS survey results, if applicable, to Quality Committee	NCQA ME 7	Annual		
Q3	Quality Committee	Present BH survey results, if applicable, to Quality Committee -	NCQA ME 7	Annual		
Q3	Quality Committee	Grievance, appeals, QOC and critical incidents (if applicable) summary report	Multiple Standards	Quarterly		
Q3 *(prior six months data)*	Credentialing Committee	Monitoring Potential Practitioner Quality Concerns Report	CR 5A	Semiannual		
Q4 *(current year - member survey data available in September*	Quality Committee	Non-Behavioral Member Experience Report	ME 7C & D	Annual		
Q4 *(current year - member survey data available in September*	Quality Committee	Behavioral Member Experience Report	ME 7E & F	Annual		
Q4	Quality Committee	Practitioner Availability Report	NET 1	Annual		
Q4	Quality Committee	Accessibility of Services Report	NET 2	Annual		
Q4	Quality Committee	Assessment of Network Adequacy	NET 3	Annual		
Q4	Quality Committee	Directory Accuracy Report	NET 5 C & D	Annual		
Q4	Quality Committee	New Member Understanding Report	ME 3C	Every 2 years		
Q4 *(current year HEDIS report and other data)*	Quality Committee	Continuity & Coordination of Medical Care Report	QI 3	Annual		
Q4 *(current year HEDIS report and other data)*	Quality Committee	Continuity & Coordination of Medical & BH Care Report	QI 4	Annual		
Q4	Medical Management Committee	IRR Testing Results/Analysis	UM 2C	Annual		
Q4	Quality Committee *or applicable subcommittee*	[DELEGATE] [QI/UM/etc.] Program (i.e. Program Description, policies, etc.)	All Delegate Standards	Annual		

Q4	Quality Committee *or applicable subcommittee*	[DELEGATE] Annual Delegated Vendor Oversight Audit results	All Delegate Standards	Annual		
Q4	Quality Committee	Present Provider Satisfaction Survey results and opportunities for improvement/action plan to Quality Committee	QI 3 & QI 4	Annual		
Q4	Quality Committee	Grievance, appeals, QOC and critical incidents (if applicable) summary report	Multiple Standards	Quarterly		
Q4	Quality Committee	Website Usability Testing Summary Report	NET 5I	Every 3 years		

Quarter *(timeframe reviewed)*	**Committee**	**Report Name**	**Related Standard**	**Reporting Period**		
Q1	Medical Management Committee	LTSS-CM Program Description	LTSS 1	Annual		
Q1	Medical Management Committee	LTSS-CM Active Participation Report	LTSS 2F-G	Annual		
Q2	Medical Management Committee	LTSS-CM Experience Report	LTSS 2A	Annual		
Q2	Medical Management Committee	LTSS-CM Effectiveness Measure Report	LTSS 2B-E	Annual		
Q3	Medical Management Committee	LTSS-Reducing Unplanned Transition Report	LTSS 3B-C	Annual		
Q4	Medical Management Committee	Summary Report for critical incidents	LTSS 1	Annual		

Nebraska Total Care
Quality Work Plan

2022 WORK PLAN TEMPLATE [insert a row below all applicable activities if State or CMS submission is required for specific documents]
Green font designates changes/clarifications made to the original current year version

RESPONSIBLE DEPARTMENT: QUALITY										
2022 Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**	**Committee**	**Scheduled**	**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** **Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.**
	Quality Structure	Review/monitor all clinical quality and service functions of the health plan and provide oversight of all subcommittees.	Conduct regularly scheduled **Quality Committee** meetings, at least quarterly and as needed.	Quality VP/Director	QAPIC	February 1, 2022 May 3, 2022 August 2, 2022 November 1, 2022	**February 1, 2022** **May 3, 2022** August 2, 2022 November 1, 2022			
	Quality Structure	Review/monitor performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings.	Conduct regularly scheduled **Performance Improvement Team** meetings, recommended at least ten (10) times per year.	Quality VP/Director	PIC	January 12, 2022 February 8, 2022 March 9, 2022 April 13, 2022 May 11, 2022 June 8, 2022 July 13, 2022 August 10, 2022 September 14, 2022 October 12, 2022 November 9, 2022 December 14, 2022	**January 12, 2022** **February 8, 2022** **March 9, 2022** **April 13, 2022** **May 11, 2022** **June 8, 2022** July 13, 2022 August 10, 2022 September 14, 2022 October 12, 2022 November 9, 2022 December 14, 2022			
	Safety of Clinical Care	Review alleged inappropriate services by a practitioner/provider and apply clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan.	Conduct scheduled **Peer Review Committee** meetings as needed.	Quality VP/Director	Peer Review	As Needed				
	Quality Structure	Review/monitor performance improvement efforts and activities as related to additional committees' purpose.	Add additional committees to the *Responsible Department Activity* column, may include **Cultural Competency Committee**, **Quality Measures Steering Committee** (previously HEDIS Steering Committee), **Grievance and Appeals Committee**, **Provider Advisory Committee**, **Hospital Advisory Committee**, **Member Advisory Committee**, **Community Advisory Committee**, **Tribal Advisory Committee**, **Compliance Committee**, or other committees identified by the health plan.	Quality VP/Director	All Committees	See Committees & Dates Reflected				
NCQA QI 1	Quality Structure	Develop/revise a comprehensive document that describes the Quality Program structure, operational processes, responsibilities, etc. The Quality Program Description is updated annually to incorporate findings from the annual evaluation.	Present **Quality Program Description** to Quality Committee for review and approval.	Quality VP/Director	QAPIC	Tuesday, November 1, 2022				
NCQA QI 1	Quality Structure	Develop/revise a work plan that reflects ongoing quality activities; the Quality Work Plan is updated annually, incorporating findings from the annual evaluation.	Present **Quality Work Plan** to Quality Committee for review and approval and provide regular updates (e.g. quarterly) to the committee as work plan is executed throughout the year.	Quality VP/Director	QAPIC	Tuesday, February 1, 2022	**Februray 1, 2022**			
NCQA QI 1	Quality Structure	Complete an annual evaluation addressesing the effectiveness of the Quality Program as outlined in the Quality Program Description and Quality Work Plan	Present **Quality Program Evaluation** to Quality Committee for review and approval.	Quality VP/Director	QAPIC	Tuesday, February 1, 2022	**Februray 1, 2022**			
	Quality Structure	Create an inclusive document that describes the approach to address the cultural and linguistic needs of members and review/update annually.	Present **Cultural Competency Plan** to Quality Committee for review and approval.	Quality VP/Director	QAPIC	Tuesday, August 2, 2022				
NCQA QI 1	Quality Structure	Assure Board of Directors oversight of the Quality Program through annual approval of the triology documents.	Receive Board Of Directors approval for **Annual Evaluation, Quality Program Description**, and **Quality Work Plan**.	Quality VP/Director	BOD	August, 2022				
Multiple Standards	Quality Structure	Assure all quality policies are updated on no less than an annual basis, reflect current quality processes, and meet all regulatory and accreditation requirements.	Review and update all Quality policies and procedures.	Quality VP/Director	QAPIC	February 1, 2022 May 3, 2022 August 2, 2022 November 1, 2022	**February 1, 2022** **May 3, 2022** August 2, 2022 November 1, 2022			
	Quality of Clinical Care	Adopt evidence-based guidelines to ensure appropriate standards of care are followed by practitioners/providers in making healthcare decisions for clinical and behavioral healthcare services.	Present Preventive Health/Clinical Practice Guidelines to Quality Committee for apprpoval. (*Note: guidelines are approved annually by Centene Clinical Policy Committee, may also be approved by local committee*).	Quality VP/Director	CAC	January 25, 2022 April 26, 2022 July 26, 2022 October 25, 2022	**January 25, 2022** **April 26, 2022** July 26, 2022 October 25, 2022			
NCQA ME 7	Members' Experience	Conduct annual member experience survey(s) as applicable to meet regulatory and accreditation requirements; identify and initiate interventions to improve member experience.	Present CAHPS/QHP survey results to Quality Committee and opportunities for improvement/action plan.	Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				

Nebraska Total Care
Quality Work Plan

NCQA ME 7	Members' Experience	Conduct annual health outcomes survey (HOS) as applicable to gather clinical health status data from Medicare members to identify and initiate interventions to improve members' health.	Present HOS survey results, if applicable, to Quality Committee and opportunities for improvement/action plan.	Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA ME 7	Members' Experience	Conduct annual behavioral health member experience survey(s) as applicable to meet regulatory and accreditation requirements; identify and initiate interventions to improve member experience.	Present behavioral health experience survey results to Quality Committee and opportunities for improvement/action plan.	Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA ME 7	Members' Experience	Analyze member experience annually through monitoring of member complaints, appeals, and CAHPS/QHP results, and identify improvement opportunities and interventions.	Present **Non-Behavioral Health Member Experience Report** to Quality Committee for review and approval.	Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA ME 7	Members' Experience	Analyze behavioral health member experience annually through monitoring of member complaints, appeals, and behavioral health survey results, and identify improvement opportunities and interventions.	Present **Behavioral Health Member Experience Report** to Quality Committee for review and approval.	Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA QI 3	Quality of Clinical Care	Annually monitor continuity and coordination of care between medical providers, and act to improve coordination of medical care.	Present **Continuity and Coordination of Medical Care Report** to Quality Committee for review and approval.	Quality VP/Director Med Management VP/Director	CAC QAPIC	October 25, 2022 November 1, 2022				
NCQA QI 4	Quality of Clinical Care	Annually monitor continuity and coordination of care between medical providers and behavioral health providers, and act to improve coordination.	Present **Continuity and Coordination of Medical Care and BH Report** to Quality Committee for reivew and approval.	Quality VP/Director Med Management VP/Director	CAC QAPIC	October 25, 2022 November 1, 2022				
Multiple Standards	Quality Structure	Assure Quality Committee oversight of applicable functional areas/programs through annual approval of program descriptions.	Present **PHM, CM, UM and LTSS (if applicable) Program Descriptions Executive Summary** to Quality Committee for review and approval.	Quality VP/Director	CAC UM	CM/PHM July 26, 2022/August 2, 2022 UM July 26, 2022/July 28, 2022				

Nebraska Total Care
Quality Work Plan

RESPONSIBLE DEPARTMENT: COMPLIANCE										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
	Quality Structure	Provides guidance/oversight of operations affecting the scope of functions of delegated vendors, subcontractors, and Centene specialty companies that provide services to members.	Conduct regularly scheduled **Joint Operations Committee** meetings, at least quarterly and as needed.	Compliance VP/Director	JOC	EPC& Pharm_ Feb 17, 2022 EPC & Pharm_May 19, 2022 EPC& Pharm_ Nov 10, 2022 Envolve Vision- Dental -Jun 1, 2022 Envolve Vision- Dental -Aug 17,2022 Envolve Vision- Dental -Nov 16, 2022 NIA_Feb 24 & 28, 2022 NIA_May 10, 2022 NIA_August 10, 2022 NIA_ Nov 10, 2022	**EPC& Pharm_ Feb 17, 2022** **EPC & Pharm_May 19, 2022** EPC& Pharm_ Nov 10, 2022 **Envolve Vision- Dental -Jun 1, 2022** Envolve Vision- Dental -Aug 17,2022 Envolve Vision- Dental -Nov 16, 2022 **NIA_Feb 24 & 28, 2022** **NIA_May 10, 2022**			
NCQA Delegation Standards	Quality Structure	Assure annual approval of the delegate's program, as applicable to the delegated activities.	Present [DELEGATE] [QI/UM/etc.] Program (i.e. Program Description, policies, etc.) to Quality Committee (or applicable subcommittee)	Compliance VP/Director	QAPIC	February 1, 2022 May 3, 2022 August 2, 2022 November 1, 2022	**February 1, 2022** **May 3, 2022** August 2, 2022 November 1, 2022			
NCQA Delegation Standards	Quality Structure	Provide annual oversight of the delegate's performance per delegated activitives, e.g. evaluation against state/federal/accreditation requirements, file review, etc.	Present [DELEGATE] Annual Delegated Vendor Oversight Audit results to Quality Committee (or applicable subcommittee)	Compliance VP/Director	QAPIC	February 1, 2022 May 3, 2022 August 2, 2022 November 1, 2022	**February 1, 2022** **May 3, 2022** August 2, 2022 November 1, 2022			

RESPONSIBLE DEPARTMENT: NETWORK/CONTRACTING										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA PHM 3	Quality of Service	Review health plan support of practitioners/providers in moving towards value-based care annually, i.e. to manage population health and total cost of care.	Present overview of providers incentive models (e.g. NCQA Value Based Payment report/worksheet, P4P reporting, value-based reporting suite, etc.) to Quality Committee for review.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				
NCQA NET 1 & ME 2	Quality of Service	Monitor the cultural and linguistic needs of members and evaluate the practitioner network against member needs. Annually monitor the availability of PCP, high-volume and high-impact specialists, and behavioral health practitioners against geographic and numeric standards.	Present **Practitioner Availability Report** to Quality Committee for review and approval.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				
NCQA NET 2	Quality of Service	Annually monitor compliance with appointment accessibility and after-hours care for PCPs, high-volume and high-impact specialist, and behavioral health practitioners.	Present **Accessibility of Services Report** to Quality Committee for review and approval.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				
NCQA NET 3	Quality of Service	Analyze member experience with network adequacy and take action to improve access, on an annual basis.	**Present Assessment of Network Adequacy Report** to Quality Committee for review and approval.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				
NCQA NET 5	Quality of Service	Annually evaluate accuracy of the physician directory and identify opportunities/actions to improve the accuracy.	Present **Directory Accuracy Report** to Quality Committee for review and approval.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				
NCQA NET 5	Quality of Service	Evaluate the web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years.	Present **Website Usability Testing Summary Report** to Quality Committee for review.	Network/Contracting VP/Director	PIC QAPIC	October 12, 2022 November 1, 2022				

RESPONSIBLE DEPARTMENT: MEDICAL MANAGEMENT - UTILIZATION MANAGEMENT ACTIVITIES										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
	Quality Structure	Provide oversight and operating authority of all medical management activities, including utilization management and care management processes, policies and procedures.	Conduct regularly scheduled **Medical Management Committee** meetings, quarterly and as needed.	Med Management VP/Director	UM	January 27, 2022 April 28, 2022 July 29, 2022 October 27, 2022	**January 27, 2022** **April 28, 2022** July 29, 2022 October 27, 2022			
NCQA UM 1	Quality Structure	Develop/revise a comprehensive document that describes the Utilization Management Program structure, operational processes, responsibilities, etc. The Utilization Management Program Description is updated annually to incorporate findings from the annual evaluation.	Present **Utilization Management Program Description** to Quality Committee for review and approval.	Med Management VP/Director	UM	Thursday, July 28, 2022				

Nebraska Total Care
Quality Work Plan

NCQA UM 1	Quality Structure	Complete an annual evaluation addressesing the effectiveness of the Utilization Management Program as outlined in the Utilization Management Description.	Present **Utilization Management Program Evaluation** to Quality Committee for review and approval.	Med Management VP/Director	UM	Thursday, April 28, 2022	**Thursday, April 28, 2022**			
NCQA UM 2	Quality of Clinical Care/ Safety of Clinical Care	Assure evidence-based criteria is used for making utilization decisions when determining the medical appropriateness of services and that criteria is updated as appropriate and reviewed annually.	Present medical necessity criteria (e.g. clinical policies, InterQual, Medicare LCDs/NCDs, etc.) to Medical Management Committee for review and approval. *(Note: critieria is approved annually by Centene Clinical Policy Committee, may also be approved by local committee).*	Med Management VP/Director	UM	January 27, 2022 April 28, 2022 July 29, 2022 October 27, 2022	**January 27, 2022** **April 28, 2022** July 29, 2022 October 27, 2022			
NCQA UM 2	Quality of Clinical Care/ Safety of Clinical Care	Evaluate consistency of utilization management decision-making through annual Interrater Reliability (IRR) testing and implement actions for improvement as needed.	Present **IRR Testing Report** to Medical Management Committee for review.	Med Management VP/Director	UM	Thursday, April 28, 2022	**Thursday, April 28, 2022**			
NCQA UM 5	Quality of Clinical Care/ Safety of Clinical Care	Monitor the timeliness of utilization management decisions and notifications no less than annually to ensure compliance with state/federal/accreditation requirements.	Present **Utilization Management Timeliness Report** (medical, BH, and pharmacy) to Medical Management Committee for review.	Med Management VP/Director	UM	January 27, 2022 April 28, 2022 July 29, 2022 October 27, 2022	**January 27, 2022** **April 28, 2022** July 29, 2022 October 27, 2022			

Nebraska Total Care
Quality Work Plan

RESPONSIBLE DEPARTMENT: MEDICAL MANAGEMENT - POPULATION HEALTH MANAGEMENT ACTIVITIES										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA PHM 1	Quality of Clinical Care	Develop/revise a comprehensive document annually that describes the population health management (PHM) strategy for meeting the care needs of members, including goals, services, activities, etc.	Present **Population Health Management Strategy** to Quality Committee for review and approval.	Med Management VP/Director Quality VP/Director	CAC QAPIC	07/26/2022 08/02/2022				
NCQA PHM 2	Quality of Clinical Care	Annually assess the characteristics and needs of the health plan population and determine if current PHM programs, services, and resources are meeting member needs.	Present **Population Assessment** to Quality Committee for review and approval.	Med Management VP/Director Quality VP/Director	CAC QAPIC	07/26/2022 08/02/2022				
NCQA PHM 2	Quality of Clinical Care	Stratify/segment the entire enrolled population into subsets for targeted intervention based on member health needs on an annual basis.	Present **PHM Stratification/Segmentation Report** to Quality Committee for review and approval.	Med Management VP/Director Quality VP/Director	CAC QAPIC	07/26/2022 08/02/2022				
NCQA PHM 6	Quality of Clinical Care	Analyze PHM strategy activities and identify opportunities for improvement annually.	Present **PHM Effectiveness Report** to Quality Committee for review and approval.	Med Management VP/Director Quality VP/Director	CAC QAPIC	07/26/2022 08/02/2022				
RESPONSIBLE DEPARTMENT: MEDICAL MANAGEMENT - CARE MANAGEMENT ACTIVITIES										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA PHM 5	Quality Structure	Develop/revise a comprehensive document that describes the Care Management Program structure, operational processes, responsibilities, etc.	Present **Care Management Program Description** to Quality Committee for review and approval.	Med Management VP/Director	CAC QAPIC	July 26, 2022 August 2, 2022				
NCQA PHM 6	Members' Experience	Conduct satisfaction surveys/measure experience of members participating in care management and identify opportunities/actions to improve performance.	Present care management satisfaction/experience survey results to Medical Management Committee.	Med Management VP/Director	CAC QAPIC	July 26, 2022 August 2, 2022				

Nebraska Total Care
Quality Work Plan

RESPONSIBLE DEPARTMENT: MEMBER SERVICES										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
	Members' Experience	Monitor compliance with customer service telephone accessibility standards (e.g. Average Speed to Answer, abandoment rate, etc.) no less than annually.	Present Customer Services telephone access report to Quality Committee.	Member Services VP/Director	PIC	January 12, 2022 April 13, 2022 July 13, 2022 October 12, 2022	**January 12, 2022** **April 13, 2022** July 13, 2022 October 12, 2022			
NCQA ME 5	Members' Experience	Monitor the quality and accuracy of pharmacy benefit information communicated to members via the web and telephonically and perform analysis annually.	Present **Quality & Accuracy of Pharmacy Benefit Information Report** to Quality Committee for review and approval.	Member Services VP/Director Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022	**Pending Coroprate Credit**			
NCQA ME 6	Members' Experience	Monitor the quality and accuracy of benefit information communicated to members via the web and telephonically and perform analysis annually.	Present **Quality & Accuracy of Member Benefit Information Report** to Quality Committee for review and approval.	Member Services VP/Director Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA ME 6	Members' Experience	Monitor email inquiry turnaround time and quality of responses and perform analysis annually.	Present **Email Response Analysis Report** to Quality Committee for review and approval.	Member Services VP/Director Quality VP/Director	PIC QAPIC	July 13, 2022 August 2, 2022				

RESPONSIBLE DEPARTMENT: PROVIDER RELATIONS										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA QI 3 & QI 4	Quality of Service	Conduct annual provider experience survey(s) as applicable to meet regulatory and accreditation requirements; identify and initiate interventions to improve provider experience.	Present Provider Satisfaction Survey results and opportunities for improvement/action plan to Quality Committee for review and recommendations.	Provider Relations VP/Director	QAPIC	Tuesday, November 1, 2022				

RESPONSIBLE DEPARTMENT: GRIEVANCE AND APPEALS										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA ME 7 NCQA UM 8	Members' Experience	Review and update Grievance System policy (or individual complaint/grievance/appeals policies) annually to ensure grievance and appeal processes are compliant with state/federal/accreditation requirements.	Present applicable policy(s) to Quality Committee for review and approval.	G&A Manager	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA ME 7	Members' Experience	Monitor member and provider grievances and appeals no less than annually.	Present complaint/grievance and appeals data to Quality Committee for review.	G&A Manager	PIC QAPIC	July 13, 2022 August 2, 2022				
NCQA CR 5	Members' Experience	Monitor complaints and quality of care (QOC) incidents/adverse events by individual practitioner no less than every 6 months in order to take appropriate action against practitioners if necessary.	Present **Monitoring Potential Practitioner Quality Concerns Report** to Credentialing Committee for review and appropriate action as needed.	G&A VP/Director	CR	Thursday, June 30, 2022				

RESPONSIBLE DEPARTMENT: PHARMACY										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA UM 11	Quality Structure	Provide oversight and operating authority of the pharmacy program, including pharmacy policies and procedures, pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities.	Conduct regularly scheduled **Pharmacy and Therapeutics Committee** meetings, at least quarterly and as needed.	Chief Medical Director Pharmacy VP/Director	P&T	January 6, 2022 April 12, 2022 July 7, 2022 October 11, 2022	**January 6, 2022** **April 12, 2022** July 7, 2022 October 11, 2022			
NCQA UM 11	Quality Structure	Provide oversight of the pharmacy program to ensure pharmacy services provided to members are compliant with state/federal/accreditation requirements no less than annually.	Present overview of pharmacy program (e.g. Pharmacy Program Description, annual summary of pharmacy activities, etc.) to Quality Committee for review.	Pharmacy Director	P&T	January 6, 2022 April 12, 2022 July 7, 2022 October 11, 2022	**January 6, 2022** **April 12, 2022** July 7, 2022 October 11, 2022			

Nebraska Total Care
Quality Work Plan

RESPONSIBLE DEPARTMENT: CREDENTIALING										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA CR 1	Quality Structure	Provide review, oversight and operating authority of the credentialing policies, activities, etc. including compliance with regulatory and accreditation requirements.	Conduct regularly scheduled **Credentialing Committee** meetings, recommended at least ten (10) times per year.	Chief Medical Director Credentialing Director	CR	2nd Monday of the Month	**Jan 10,2022** **Feb 14, 2022** **March 14,2022** **April 11, 2022** **May 9,2022**			
NCQA CR 1	Quality Structure	Provide oversight of the credentialing program to ensure credentialing activities are compliant with state/federal/accreditation requirements no less than annually.	Present annual summary of credentialing activities to Quality Committee for review (i.e. **review/approproval of credentialing policies**, annual delegate oversight audits, etc.).	Chief Medical Director Credentialing Director	CR					
RESPONSIBLE DEPARTMENT: MARKETING										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA ME 3	Members' Experience	Assess how well new members understand health plan policy and procedures and identify opportunities to improve understanding if needed.	Present **New Member Understanding Report** to Quality Committee for review and approval.	Marketing VP/Director	PIC	Thursday, August 25, 2022				

Nebraska Total Care
Quality Work Plan

RESPONSIBLE DEPARTMENT: LTSS										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
NCQA LTSS 1	Quality Structure	Develop a comprehensive document that describes the Long-Term Services and Supports (LTSS) structure, criteria, service, etc. The LTSS Case Management Description is updated annually.	Present **LTSS-CM Program Description** to Quality Committee for review and approval.	Med Management VP/Director						
NCQA LTSS 1	Safety of Clinical Care	Annually assure critical incident management system is utilized to track events that cause member harm, including follow-up processes and implementation of appropriate interventions.	Present critical incidents summary report to the Medical Management Committee for review.	Med Management VP/Director						
NCQA LTSS 2	Members' Experience	Evaluate member experience with the LTSS case management program annually through monitoring of member complaints and feedback.	Present **LTSS-CM Experience Report** to Medical Management Committee for review and approval.	Med Management VP/Director						
NCQA LTSS 2	Quality of Care	Analyze the effectiveness of the LTSS program annually through identification of improvement opportunities and interventions for specific measures.	Present **LTSS-CM Effectiveness Measure Report** to Medical Management Committee for review and approval.	Med Management VP/Director						
NCQA LTSS 2	Quality of Care	Annually measure and analyze member participation for each LTSS program.	Present **LTSS-CM Active Participation Report** to Medical Management Committee for review and approval.	Med Management VP/Director						
NCQA LTSS 3	Quality of Care	Complete an annual analysis that describes how the health plan addresses unplanned transitions and actions implemented for improvement, including high risk members, admissions to facilities and emergency rooms, etc.	Present **Reducing Unplanned Transition Report** to Quality Committee for review and approval.	Med Management VP/Director						
ADDITIONAL QUALITY IMPROVEMENT PROJECTS / CONTRACTUAL REQUIREMENTS										
Requirement/ Authoritative Source	**Scope**	**Objective**	**Activity**	**Responsible Party**			**Month/Year Completed Medicaid**	**Month/Year Completed Marketplace**	**Month/Year Completed Medicare**	**Comments** Includes periodic or ongoing evaluation and monitoring of issues identified in current/prior years that require additional follow up.
[insert authoritative source]	Quality Structure		Project Name: Project Description: Project Initiated: Project Length: This is a summary of projects-larger tracking tools may be used for specific project details.	[insert identified lead]						

Nebraska Total Care
2022 PIPs

Intervention Name	Description	Goal/Objective	Priority	Program Type	Measure(s)	Start Date	End Date	Status	Department Owner	Individual Owner	Barriers	Interventions 2021	Interventions 2022	Baseline 2019 (per MLTC guideance: Covid 2020)	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Final April 2023	Target
Project Name: All Cause Readmission	Project Description: Collaborative MCO's/MLTC Performance Improvement Project (PIP): All Cause Readmission	By completing a targeted intervention, such as the Transition of Care assessment, to members 18-64 years of age, who have an acute inpatient stay (which falls within the specifications of the PCR HEDIS measure) during the measurement year, the total observed readmission rate for HEDIS measure, Plan All Cause Readmission, will be at or below 11.0% by December 31, 2022	High	MLTC Performance Improvement Project	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. N: Count of Observed 30-day Re-admissions D: Count of Index Hospital Stays	1/1/2021	12/31/2022	In Progress	Quality	Amy Wing	Barrier 1: Lack of Provider Knowledge Method of barrier identification: Collaborative Inter-Departmental Roundtable Barrier 2: Improvement opportunity to identify and outreach members with SDOH needs or Readmission Risk Score greater or equal to 50. Method of barrier identification: Collaborative Inter-Departmental Roundtable Barrier 3: Access to care: Member lacking PCP visit within 12 months of the admission. Method of barrier identification: Collaborative Inter-Departmental Roundtable Barrier 4: Care Coordination targeted to identified vulnerable population Method of barrier identification: Collaborative Inter-	Staff Education Q1 2021 1. Newsletter article on 2021 PIPs 2. Shared with department leaders at committee meetings Member Support All Quarters 2021 1. Increase UM to CM referrals for members with readmission risk score of >/= 50; track successful outreach / outcome; 2. Telephonic outreach to members with SDOH needs Assist with access to care Q3 2021 1.Telephonic outreach to members not having PCP claim in past 12 mo who have had IP stay Provider Education All 2021 1. Provider News and Updates article Q2 2021 2. JOC / VBC / Townhall meetings report out Q2 2021 3. HEDIS Quick Reference Guide on website Provider Resources Q1 2021 1. Provider news & updates PIP article / Provider Newsletter articles 2. Online training (ie: LAIA, CM services, SDOH, BH 101, SMART goals, Strength-based treatment, Poverty Competency for Providers) Target Outreach to vulnerable population Q4 2021	1. Assess data for validity in tracking TOCs; do analysis of trends in Dx, zip code/county 2. Data shows high re-admission of behavioral health diagnosis 3. Round table with PHM to discuss barriers / actions 4: Round table with Pharmacy pending 6.22.22 (unable to join PHM meeting) 5. **New HBR initiative r/t schizophrenia - track 46 members identifies on report; 35 not in case management (9 with BH CM, 2 in monitoring status) referrals are being made for those 35 for outreach	N: 175 D: 1589 R: 11.01%	N: 59 D: 421 R: 14.01%	N: 124 D: 936 R: 13.25%	N: 165 D: 1405 R: 11.74%	N: 254 D: 1942 R: 13.08%	N: 84 D: 680 R: 12.35%						R: ≤11.0%

Intervention Name	Description	Goal/Objective	Priority	Program Type	Measure(s)	Start Date	End Date	Status	Department Owner	Individual Owner	Barriers	Interventions 2022	Interventions 2023	Baseline 2022	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Final April 2024	Target
Maternal Child Health	Project Description: MLTC Performance Improvement Project (PIP); chosen by the HP Maternal Child Health: Increasing Notification of Pregnancy (NOP) rate for Nebraska Total Care pregnant members	By the end of measurement period, Nebraska Total Care aims to increase the percentage of deliveries with a completed Notification of Pregnancy (NOP) by 3%.	HIGH	0	Nebraska Total Care expectant members who have a delivery in the measurement period (baseline: January 1, 2022 – December 31, 2022; remeasurement period: January 1, 2023 – December 31, 2023). N: Number of pregnant Nebraska Total Care members that have a completed NOP 252 or less days prior to delivery date during the measurement period D: Total number of pregnant Nebraska Total Care members that deliver in the measurement period.	1/1/2022	12/31/2022	In Progress	Quality	Amy Wing	Late entry to care Pregnant moms needing medicare to cover pregnancy do not know how to access medicaid and do not go to the provider until they have coverage for the bill Bundle billing state - no claim comes in to alert HP to member expecting a baby Another form for providers to fill out Members/Providers unaware of what / how / where / why to fill out form	2022: Baseline year HP is working on corporate goal to improve for CY 2022 POM / Email outreach to members with potential claim r/t pregnancy (413 report) My Health Pays reward for members filling out form Payment to providers for filling out forms Considering nurse claim or penny claim for initial visit		Pending Historical Data 2021: N: 1704 D: 3007 R: 56.7%	N: 374 D: 695 R: 53.81%										By the end of measurement period, Nebraska Total Care aims to increase the percentage of deliveries with a completed Notification of Pregnancy (NOP) by 3%. Baseline data is measured in 2022

Nebraska Total Care
2022 Interventions

Workplan ID	States	Organization	Intervention Name	Chapters	Measures	Program Type	Contracts	Line of Business	Calendar Year	Cost of Initiative	Number of Employees	Financial Risks	Medicaid State Requirements	Medicare State Requirements	Additional Identifiers	Actual Start Date	End Date	Status	Department Owner	Individual Department	Cross Functional Individual Owner	Cross Functional Individual Owner Department	Intervention Description	Results/MEASUREMENT/Notes	Barriers
8447	NE	CENTENE	Provider Education	HEDIS	CIS - Childhood Immunization Combo 10,WCC - Weight Assess BMI Percentile Documentation - Total,WCC - Weight Assess Counseling on Nutrition - Total,WCC - Weight Assess Counseling on Physical Activity - Total,W15 - Well Child Mth Six or more well child visits,W30 - Well Child Visits in the First 30 Months of Life (previously W15),BCS - Breast Cancer Screening,CDC - Diabetes HbA1c < 8,CDC - Diabetes BP < 140/90,CBP - Controlling Blood Pressure,CDC - Diabetes - Dilated Eye Exam,CCS - Cervical Cancer Screen - Pap Test,CWP - Appropriate Testing for Pharyngitis,CHL - Chlamydia Testing	HEALTH PLAN		MEDICAID	2022	0	2	WITHHOLDS	N/A	N/A	N/A	01/01/2022	12/31/2022	ON TRACK	Laurie Krause	POPULATION HEALTH	Jennifer Newcombe	PROVIDER REL/ENG	HEDIS measure education; any P4P incentives reviewed; list of patients given for care gaps; HEDIS hints		VBCs meetings not always connecting directly with the provider
4542	NE	CENTENE	Care Coordination--all VBC groups	CAHPS	CC - Care Coordination	PROVIDER		MEDICAID	2021	0	2					01/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	PROVIDER RELATIONS/ENG	Amy Wing	QUALITY	Care Coordination	: Monthly meeting to discuss high utilizers of services, problematic discharge planning and continuity care	NA
4541	NE	CENTENE	OB Record Project--NHN/CHI	HEDIS	PPC - Prenatal and Postpartum Care	PROVIDER		MEDICAID	2021	0	2					02/01/21	04/30/21	DELAYED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	Prenatal/Postpartum medical records	: Initial education provided, ongoing support to providers as needed	NA
4540	NE	CENTENE	OB Record Project--NHN/CHI	HEDIS	PPC - Prenatal and Postpartum Care	PROVIDER		MEDICAID	2021	0	2					01/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	Prenatal/Postpartum medical records	: Initial education provided, ongoing support to providers as needed	NA
4539	NE	CENTENE	SDS File Creation--LMEP (Athena)	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	DELAYED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4538	NE	CENTENE	SDS File Creation--Mary Lanning	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4537	NE	CENTENE	SDS File Creation--Beatrice	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4536	NE	CENTENE	SDS File Creation--Faith Regional	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4535	NE	CENTENE	SDS File Creation--Regional West	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	DELAYED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4534	NE	CENTENE	SDS File Creation--Bryan Health	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4533	NE	CENTENE	SDS File Creation--Boystown	HEDIS		PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	DELAYED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
4532	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CDC <8 Comprehensive Diabetes Care - HbA1c controlled (<8)	: Initial education provided, ongoing support to providers as needed	NA
4531	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CBP- Controlling High Blood Pressure	3/20/2022: HEDIS CBP review; member lists provided; HEDIS hints review and available to all providers----: Initial education provided, ongoing	NA

Nebraska Total Care
2022 Interventions

4530	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CCS Cervical Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4529	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunization: Combo 2	: Initial education provided, ongoing support to providers as needed	NA
4528	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CIS - Childhood Immunization Status	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CIS10 - Childhood Immunization Status: Combo 10	: Initial education provided, ongoing support to providers as needed	NA
4527	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	STARTED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	BCS Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4526	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CDC <8 Comprehensive Diabetes Care - HbA1c controlled (<8)	: Initial education provided, ongoing support to providers as needed	NA
4525	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CBP- Controlling High Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
4524	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CCS Cervical Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4523	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunization: Combo 2	: Initial education provided, ongoing support to providers as needed	NA
4522	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	CIS - Childhood Immunization Status	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CIS10 - Childhood Immunization Status: Combo 10	: Initial education provided, ongoing support to providers as needed	NA
4521	NE	CENTENE	Provider Education--Sydney Clinics	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	BCS Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4520	NE	CENTENE	Provider Education--Bryan Health	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CDC <8 Comprehensive Diabetes Care - HbA1c controlled (<8)	: Initial education provided, ongoing support to providers as needed	NA
4519	NE	CENTENE	Provider Education--Bryan Health	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CBP- Controlling High Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
4518	NE	CENTENE	Provider Education--Bryan Health	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CCS Cervical Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4517	NE	CENTENE	Provider Education--Bryan Health	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunization: Combo 2	: Initial education provided, ongoing support to providers as needed	NA
4516	NE	CENTENE	Provider Education--Bryan Health	HEDIS	CIS - Childhood Immunization Status	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CIS10 - Childhood Immunization Status: Combo 10	: Initial education provided, ongoing support to providers as needed	NA
4515	NE	CENTENE	Provider Education--Bryan Health	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	BCS Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4514	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CDC <8 Comprehensive Diabetes Care - HbA1c controlled (<8)	: Initial education provided, ongoing support to providers as needed	NA
4513	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CBP- Controlling High Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA

Nebraska Total Care
2022 Interventions

4512	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CCS Cervical Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4511	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunization: Combo 2	: Initial education provided, ongoing support to providers as needed	NA
4510	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CIS - Childhood Immunization Status	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CIS10 - Childhood Immunization Status: Combo 10	: Initial education provided, ongoing support to providers as needed	NA
4509	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	BCS Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4508	NE	CENTENE	Provider Education-Model 1	HEDIS	WCC - Weight Assess Counseling on Physical Activity - Total	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	WCC Weight Assessment for Children / Adolescents Counseling Physical Activity ages 12-17	: Initial education provided, ongoing support to providers as needed	NA
4507	NE	CENTENE	Provider Education-Model 1	HEDIS	WCC - Weight Assess Counseling Nutrition - Total	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	WCC Weight Assessment for Children / Adolescents Nutrition Counseling ages 12-17	: Initial education provided, ongoing support to providers as needed	NA
4506	NE	CENTENE	Provider Education-Model 1	HEDIS	WCC - Weight Assess BMI Percentile Documentation - Total	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	WCC Weight Assessment for Children / Adolescents BMI ages 12-17	: Initial education provided, ongoing support to providers as needed	NA
4505	NE	CENTENE	Provider Education	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CDC <8 Comprehensive Diabetes Care - HbA1c controlled (<8)	: Initial education provided, ongoing support to providers as needed	NA
4504	NE	CENTENE	Provider Education	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CBP- Controlling High Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
4503	NE	CENTENE	Provider Education	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CCS Cervical Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
4502	NE	CENTENE	Provider Education	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunization: Combo 2	: Initial education provided, ongoing support to providers as needed	NA
4501	NE	CENTENE	Provider Education	HEDIS	CIS - Childhood Immunization Status	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	CIS10 - Childhood Immunization Status: Combo 10	: Initial education provided, ongoing support to providers as needed	NA
4500	NE	CENTENE	Provider Education	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2021	0	2					02/01/21	12/31/21	COMPLETED	Laurie Krause Jessika Black	ADMIN/OPS	Amy Wing	QUALITY	BCS Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Care Management Program	HEDIS	APP - First-Line Psychosocial Care	HEALTH PLAN		MEDICAID	2022	0						2/14/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	Brown Stanley Safety Plan (CM dept)		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Rating of All Health Care	HEALTH PLAN		MEDICAID	2022	0	50					4/6/2022	4/6/2022	COMPLETED	Janelle Armstrong	MARKETING	Joni Thomas	POPULATION HEALTH	Lunch and Learn: Heart Ministry Center		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Care	HEALTH PLAN		MEDICAID	2022	0						3/25/2022	3/25/2022	COMPLETED	Janelle Armstrong	MARKETING	Paula Stapleton	POPULATION HEALTH	SDOH: Social Needs Self-Assessment		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Care	HEALTH PLAN		MEDICAID	2022	0						3/24/2022	3/24/2022	COMPLETED	Janelle Armstrong	MARKETING	Laurie Krause	ADMIN OPS	Training: Epilepsy First Aid		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Plan Administration	HEALTH PLAN		MEDICAID	2022	0						3/15/2022	3/15/2022	COMPLETED	Janelle Armstrong	MARKETING	Jennifer Cintani	COMPLIANCE	Video: Keeping Protected Health Information Safe (PHI)		
	NE	CENTENE	CNET Employee Intranet	HEDIS	COL - Colorectal Cancer Screening	HEALTH PLAN		MEDICAID	2022	0						3/11/2022	3/11/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	March is National Colorectal Cancer Awareness Month		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Plan Administration	HEALTH PLAN		MEDICAID	2022	0						2/28/2022	2/28/2022	COMPLETED	Janelle Armstrong	MARKETING	Jennifer Cintani	COMPLIANCE	Compliance Corner: Minimum Necessary Standard		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						2/23/2022	2/23/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Combating Social Isolation in Schools		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						2/11/2022	2/11/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Literacy: BEHIND the SCENES		
	NE	CENTENE	CNET Employee Intranet	CAHPS	WCC - Weight Assess Counseling on Physical Activity - Total	MEMBER		MEDICAID	2022	0						2/9/2022	2/9/2022	COMPLETED	Janelle Armstrong	MARKETING	Penny Parker	MARKETING	Community Outreach - Kearney Fitness Challenge		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						2/1/2022	2/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Literacy: Work with PROVIDERS		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						12/28/2021	12/28/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Literacy: TALK to members		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						12/16/2021	12/16/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Literacy: Plain Language		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						12/6/2021	12/6/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Literacy: Community Impact		
	NE	CENTENE	CNET Employee Intranet	HEDIS	BCS - Breast Cancer Screening	HEALTH PLAN		MEDICAID	2022	0						10/25/2021	10/25/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	It Is National Breast Cancer Awareness Month		
	NE	CENTENE	CNET Employee Intranet	HEDIS	CDC - Comprehensive Diabetes Care	HEALTH PLAN		MEDICAID	2022	0						10/22/2021	10/22/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Diabetes Coaching Success; Meet Debra		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Access to Information	HEALTH PLAN		MEDICAID	2022	0						10/18/2021	10/18/2021	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	October Is Health Literacy Month		
	NE	CENTENE	CNET Employee Intranet	CAHPS	CAHPS - Plan Administration	HEALTH PLAN		MEDICAID	2022	0						3/15/2022	3/15/2022	COMPLETED	Janelle Armstrong	MARKETING	Jennifer Cintani	COMPLIANCE	CNET: Keeping Protected Health Information Safe (PHI)		
	NE	CENTENE	Direct Mailer	HEDIS	APP - First-Line Psychosocial Care	MEMBER		MEDICAID	2022	0						2/11/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	Choose Tomorrow Suicide Prevention Postcards (CM)		
	NE	CENTENE	Email Campaign	HEDIS	ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						1/11/2022	1/11/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: ADD -ADHD Initiation		
	NE	CENTENE	Email Campaign	HEDIS	ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						2/1/2022	2/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: ADD -ADHD Initiation		
	NE	CENTENE	Email Campaign	HEDIS	ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						3/1/2022	3/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: ADD -ADHD Initiation		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Email Campaign	HEDIS	AMM - Antidepressant Medication Management	MEMBER		MEDICAID	2022	0						2/16/2022	2/16/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: AMM Antidepressant Initiation		
	NE	CENTENE	Email Campaign	HEDIS	AMM - Antidepressant Medication Management	MEMBER		MEDICAID	2022	0						3/23/2022	3/23/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: AMM Antidepressant Initiation		
	NE	CENTENE	Email Campaign	HEDIS	AMM - Antidepressant Medication Management	MEMBER		MEDICAID	2022	0						1/21/2022	1/21/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: AMM Antidepressant maintenance		
	NE	CENTENE	Email Campaign	HEDIS	AMR - Asthma Med Ratio	MEMBER		MEDICAID	2022	0						2/13/2022	2/13/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: AMR Asthma Breathe Better		
	NE	CENTENE	Email Campaign	HEDIS	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						2/11/2022	2/11/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APM Metabolic Monitor		
	NE	CENTENE	Email Campaign	HEDIS	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						3/24/2022	3/24/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APM Metabolic Monitor		
	NE	CENTENE	Email Campaign	HEDIS	BCS - Breast Cancer Screening	MEMBER		MEDICAID	2022	0						4/5/2022	4/5/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: BCS Mammogram Bus		
	NE	CENTENE	Email Campaign	CAHPS	CAHPS - Adult-Rating of Health Plan	MEMBER		MEDICAID	2022	0						2/14/2022	2/14/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: CAHPS Thank You Precondition		
	NE	CENTENE	Email Campaign	HEDIS	CBP - Controlling Blood Pressure	MEMBER		MEDICAID	2022	0						3/2/2022	3/2/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: CBP Control Blood Pressure/Monitor		
	NE	CENTENE	Email Campaign	HEDIS	CDC - Comprehensive Diabetes Care	MEMBER		MEDICAID	2022	0						2/21/2022	2/21/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: CDC Diabetes Screening		
	NE	CENTENE	Email Campaign	HEDIS,CAHPS	CAHPS - Access to Information,CBP - Controlling Blood Pressure,ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						1/14/2022	1/14/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Member Newsletter Q1		
	NE	CENTENE	Email Campaign	HEDIS,CAHPS	CAHPS - Access to Care,HDO - Use of Opioids at High Dosage,COU - Risk of Continued Opioid Use - 15 day rate,COU - Risk of Continued Opioid Use - 31 day rate,UOP - Use of Opioids from Multiple Providers	MEMBER		MEDICAID	2022	0						4/13/2022	4/13/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Member Newsletter Q2		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Email Campaign	HEDIS,CAHPS	Fluvention, CAHPS - Annual Flu Vaccine, AAP - Adult Access to Preventive/Ambulatory Health Services, BCS - Breast Cancer Screening, CCS - Cervical Cancer Screening, CIS - Childhood Immunization Status, WCV - Child and Adolescent Well-Care Visits, IMA - Immunizations for Adolescents, LSC - Lead Screening in Children, PPC - Prenatal and Postpartum Care, W30 - Well–Child Visits in the First 30 Months	MEMBER		MEDICAID	2022	0							1/24/2022	1/24/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: My Health Pays Rewards		
	NE	CENTENE	Email Campaign	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0							1/4/2022	1/4/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: New Year Goals Video		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							1/20/2022	1/20/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: PPC Postpartum		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							2/10/2022	2/10/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: PPC Postpartum		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							3/24/2022	3/24/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: PPC Postpartum		
	NE	CENTENE	Email Campaign	HEDIS	SSD, SMD,SMC, SAA Schizophrenia	MEMBER		MEDICAID	2022	0							3/21/2022	3/21/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: SSD, SMD,SMC, SAA Schizophrenia		
	NE	CENTENE	Email Campaign	HEDIS	Tdap, PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							2/7/2022	2/7/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Tdap vaccine		
	NE	CENTENE	Email Campaign	HEDIS,CAHPS	CAHPS - Access to Care, AAP - Adult Access to Preventive Ambulatory Health Services	MEMBER		MEDICAID	2022	0							3/28/2022	3/28/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Where to Go for Care (ER Diversion)		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							1/31/2022	1/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: WIC presentation		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0							2/27/2022	2/27/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: WIC presentation		
	NE	CENTENE	Email Campaign	HEDIS	Covid-19	MEMBER		MEDICAID	2022	0							1/1/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamie Benson	PHARMACY	Email Deploying: Covid 2nd Vaccine (weekly send)		
	NE	CENTENE	Email Campaign	HEDIS	ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0							1/1/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Amy Wing	QUALITY	Email Deploying: ADHD Rx Initiation (weekly send)		
	NE	CENTENE	Health Sheet	HEDIS	HDO - Use of Opioids at High Dosage, IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, UOP - Use of Opioids From Multiple Providers	MEMBER		MEDICAID	2022	0							3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	Getting Help for Opioid Use Disorder and Opioid Addiction (PDF)		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Health Sheet	HEDIS	HDO - Use of Opioids at High Dosage, IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment,	MEMBER		MEDICAID	2022	0						3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	How Buprenorphine Can Help with Pain and Opioid Addiction (PDF)		
	NE	CENTENE	Health Sheet	HEDIS	HDO - Use of Opioids at High Dosage, IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment,	MEMBER		MEDICAID	2022	0						3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	How to Keep You and Your Loved Ones Safe when Using Pain Medication (PDF)		
	NE	CENTENE	Health Sheet	HEDIS	HDO - Use of Opioids at High Dosage, IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment,	MEMBER		MEDICAID	2022	0						3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	What to Do During an Opioid Overdose (PDF)		
	NE	CENTENE	Health Sheet	HEDIS	APP - First-Line Psychosocial Care	MEMBER		MEDICAID	2022	0						3/17/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	Suicide Prevention Resources (PDF)		
	NE	CENTENE	Provider Newsletter (Provider Report)	HEDIS,CAHPS	PPC - Prenatal and Postpartum Care, CDC - Comprehensive Diabetes Care, General HEDIS information, Patient Documentation and Coding Tips, SSD, SMD,SMC, SAA Schizophrenia, CAHPS - Care Coordination, CAHPS - Access to Information, Psychiatric Assistance Line, preventive and clinical practice guidelines, Access to Care Management,	PROVIDER		MEDICAID	2022	0						1/1/2022	4/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Susan Jeffrey	QUALITY	Q1 Provider Newsletter (Provider Report)		
	NE	CENTENE	Provider Newsletter (Provider Report)	HEDIS,CAHPS	CAHPS - Access to Care Management, Community Health Services, Utilization Management Program, General HEDIS information, BCS - Breast Cancer Screening, CCS - Cervical Cancer Screen Pap Test, CHL - Chlamydia Testing, PCR - Plan All-Cause Readmission, W30 - Well Child Visits in the First 30 Months of Life, WCV - Child and Adolescent Well-Care Visits, Early and Periodic Screening Diagnosis & Treatment (EPSDT), LSC - Lead Screening in Children, CIS - Childhood Immunization Status, CAHPS - Plan Administration, CAHPS - Adult-Smoking Advice, CAHPS - Medical Assistance With Smoking and Tobacco Use Cessation, CAHPS - Rating of Personal Doctor, Performance Improvement Projects (PIPS), SSD - Diabetes Screening for People With Schizophrenia or Biopolar Disorder Who Are	PROVIDER		MEDICAID	2022	0						4/1/2022	7/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Susan Jeffrey	QUALITY	Q2 Provider Newsletter (Provider Report)		
	NE	CENTENE	Text/SMS Campaign	HEDIS	CBP - Controlling Blood Pressure	MEMBER		MEDICAID	2022	0						3/8/2022	3/8/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: CBP_Control blood pressure #1		
	NE	CENTENE	Text/SMS Campaign	HEDIS	CDC - Comprehensive Diabetes Care	MEMBER		MEDICAID	2022	0						2/15/2022	2/15/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: CDC_Diabetes screenings #1		
	NE	CENTENE	Text/SMS Campaign	HEDIS,CAHPS	Fluvention, CAHPS - Annual Flu Vaccine, CIS - Childhood Immunization Status	MEMBER		MEDICAID	2022	0						1/12/2022	1/12/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: Fluvention Thank You		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Text/SMS Campaign	HEDIS,CAHPS	CAHPS - Access to Information,CBP - Controlling Blood Pressure,ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						1/31/2022	1/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: Member Newsletter Q1		
	NE	CENTENE	Text/SMS Campaign	HEDIS,CAHPS	Fluvention, CAHPS - Annual Flu Vaccine, AAP - Adult Access to Preventive/Ambulatory Health Services, BCS - Breast Cancer Screening, CCS - Cervical Cancer Screening, CIS - Childhood Immunization Status, WCV - Child and Adolescent Well-Care Visits, IMA - Immunizations for Adolescents, LSC - Lead Screening in Children, PPC - Prenatal and Postpartum Care, W30 - Well–Child Visits in the First 30 Months	MEMBER		MEDICAID	2022	0						3/23/2022	3/23/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: My Health Pays Rewards		
	NE	CENTENE	Text/SMS Campaign	HEDIS,CAHPS	AAP - Adult Access to Preventive Ambulatory Health Services	MEMBER		MEDICAID	2022	0						1/27/2022	1/27/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: New Year's Goals		
	NE	CENTENE	Text/SMS Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						1/25/2022	1/25/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: PPC_Postpartum		
	NE	CENTENE	Text/SMS Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						2/8/2022	2/8/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: PPC_Postpartum		
	NE	CENTENE	Text/SMS Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						3/25/2022	3/25/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: PPC_Postpartum		
	NE	CENTENE	Text/SMS Campaign	HEDIS	Tdap, PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						2/17/2022	2/17/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: Tdap vaccine		
	NE	CENTENE	Text/SMS Campaign	CAHPS	CAHPS - Access to Care, AAP - Adult Access to Preventive Ambulatory Health Services	MEMBER		MEDICAID	2022	0						3/29/2022	3/29/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: Where to Go for Care#1 (ER Diversion)		
	NE	CENTENE	Video: YouTube/Website	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	2000	5					1/1/2022	4/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Video: New Year Goals		
	NE	CENTENE	Video: YouTube/Website	CAHPS	CAHPS - Plan Administration	MEMBER		MEDICAID	2022	2000	5					3/9/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jennifer Cintani	COMPLIANCE	Video: Keeping Your Protected Health Information Safe (PHI)		
	NE	CENTENE	Web: Additional Content	HEDIS,CAHPS	Fluvention, CAHPS - Annual Flu Vaccine, AAP - Adult Access to Preventive/Ambulatory Health Services, BCS - Breast Cancer Screening, CCS - Cervical Cancer Screening, CIS - Childhood Immunization Status, WCV - Child and Adolescent Well-Care Visits, IMA - Immunizations for Adolescents, LSC - Lead Screening in Children, PPC - Prenatal and Postpartum Care, W30 - Well–Child Visits in the First 30 Months	MEMBER		MEDICAID	2022	0						1/1/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	My Health Pays® rewards in 2022		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Adult-Smoking Advice, CAHPS - Medical Assistance With Smoking and Tobacco Use Cessation	PROVIDER		MEDICAID	2022	0						3/30/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	Tobacco Quitline updates (provider)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	MEMBER		MEDICAID	2022	0						3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Cynthia Meraz	ADMIN OPS	Appeal Form (PDF) (new BH address)		
	NE	CENTENE	Web: Additional Content	HEDIS	COVID-19	MEMBER		MEDICAID	2022	0						3/10/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	Coronavirus Information (testing information)		
	NE	CENTENE	Web: Additional Content	HEDIS	CDC - Comprehensive Diabetes Care	MEMBER		MEDICAID	2022	0						2/28/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	OneTouch Verio Member Product Flyer (PDF)		
	NE	CENTENE	Web: Additional Content	HEDIS	CDC - Comprehensive Diabetes Care	PROVIDER		MEDICAID	2022	0						2/28/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	OneTouch Verio Member Product Flyer (PDF)		
	NE	CENTENE	Web: Additional Content	HEDIS	CDC - Comprehensive Diabetes Care	PROVIDER		MEDICAID	2022	0						2/28/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	OneTouch Verio Provider Flyer (PDF)		
	NE	CENTENE	Web: Additional Content	HEDIS	CDC - Comprehensive Diabetes Care	PROVIDER		MEDICAID	2022	0						2/28/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	OneTouch Verio Pharmacy notice (PDF)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Access to Care Management	MEMBER		MEDICAID	2022	0						1/24/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Paula Stapleton	POPULATION HEALTH	Foster Parent Resource: Families Forever		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	PROVIDER		MEDICARE	2022	0						1/19/2022	1/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Mariana Johnson	PROVIDER REL/ENG	Anti-Kickback Training (PDF)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	MEDICARE		MEDICARE	2022	0						1/19/2022	1/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Mariana Johnson	PROVIDER REL/ENG	Anti-Kickback Attestation (PDF)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	MEDICARE		MEDICARE	2022	0						1/19/2022	1/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Mariana Johnson	PROVIDER REL/ENG	Fraud, Waste and Abuse Training: Medicaid and Medicare (PDF)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	MEDICARE		MEDICARE	2022	0						1/19/2022	1/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Mariana Johnson	PROVIDER REL/ENG	Fraud, Waste and Abuse Referral Form (PDF)		
	NE	CENTENE	Web: Additional Content	CAHPS	CAHPS - Plan Administration	MEDICARE		MEDICARE	2022	0						1/19/2022	1/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Mariana Johnson	PROVIDER REL/ENG	Model of Care Training 2022 (PDF)		
	NE	CENTENE	Web: Homepage Feature	HEDIS	BCS - Breast Cancer Screening	MEMBER		MEDICAID	2022	0						5/16/2021	2/2/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Breast Cancer Screenings		
	NE	CENTENE	Web: Homepage Feature	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						9/15/2021	4/5/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	24/7 Nurse Advice Line		
	NE	CENTENE	Web: Homepage Feature	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						2/2/2022	6/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Paula Stapleton	POPULATION HEALTH	SDOH: Social Needs Self-Assessment		
	NE	CENTENE	Web: Homepage Feature	HEDIS	WCC - Weight Assess Counseling Nutrition - Total	MEMBER		MEDICAID	2022	0						4/5/2022	6/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Value Add: Community Gardens		
	NE	CENTENE	Web: Homepage Feature	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						10/1/2021	1/12/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Health Risk Screening		
	NE	CENTENE	Web: Member Event	HEDIS	WCC - Weight Assess Counseling on Physical Activity - Total WCC - Weight Assess Counseling Nutrition - Total	MEMBER		MEDICAID	2022	0						1/13/2022	1/13/2022	COMPLETED	Penny Parker	MARKETING	Jamaree Maack	MARKETING	Free Nutrition and Physical Activity classes		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Web: Member Event	HEDIS	WCC - Weight Assess Counseling on Physical Activity - Total WCC - Weight Assess Counseling Nutrition - Total	MEMBER		MEDICAID	2022	0						1/20/2022	1/20/2022	COMPLETED	Penny Parker	MARKETING	Jamaree Maack	MARKETING	Free Nutrition and Physical Activity classes		
	NE	CENTENE	Web: Member Event	HEDIS	WCC - Weight Assess Counseling on Physical Activity - Total WCC - Weight Assess Counseling Nutrition - Total	MEMBER		MEDICAID	2022	0						1/27/2022	1/27/2022	COMPLETED	Penny Parker	MARKETING	Jamaree Maack	MARKETING	Free Nutrition and Physical Activity classes		
	NE	CENTENE	Web: Member Event	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						3/26/2022	3/26/2022	COMPLETED	Toni Webb	MARKETING	Jamaree Maack	MARKETING	Vison Van at Black Family Health and Wellness Health Fair		
	NE	CENTENE	Web: Member Event	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						3/25/2022	3/25/2022	COMPLETED	Toni Webb	MARKETING	Jamaree Maack	MARKETING	Vison Van at Omaha Career Center (high school)		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care Management	MEMBER		MEDICAID	2022	0						1/4/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	NEW YEAR'S GOALS		
	NE	CENTENE	Web: Member News	HEDIS,CAHPS	Fluvention, CAHPS - Annual Flu Vaccine, AAP - Adult Access to Preventive/Ambulatory Health Services, BCS - Breast Cancer Screening, CCS - Cervical Cancer Screening, CIS - Childhood Immunization Status, WCV - Child and Adolescent Well-Care Visits, IMA - Immunizations for Adolescents, LSC - Lead Screening in Children, PPC - Prenatal and Postpartum Care, W30 - Well–Child Visits in the First 30 Months	MEMBER		MEDICAID	2022	0						1/14/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	My Health Pays Rewards 2020		
	NE	CENTENE	Web: Member News	HEDIS	AMM - Antidepressant Medication Management	MEMBER		MEDICAID	2022	0						2/14/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	SEASONAL AFFECTIVE DISORDER (SAD)		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Information	MEMBER		MEDICAID	2022	0						2/28/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	CYBERBULLYING PREVENTION, YOUTH IMPACT AWARD		
	NE	CENTENE	Web: Member News	HEDIS	WCC - Weight Assess Counseling Nutrition - Total	MEMBER		MEDICAID	2022	0						3/2/2022	12/31/2022	COMPLETED	Penny Parker	MARKETING	Jamaree Maack	MARKETING	NUTRITION EDUCATION PROGRAM (NEP)		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						3/10/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	SDOH: SOCIAL NEEDS SELF-ASSESSMENT		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						3/11/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	HOW TO GET A COVID-19 TEST		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Plan Administration	MEMBER		MEDICAID	2022	0						3/17/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jennifer Cintani	COMPLIANCE	KEEPING YOUR PROTECTED HEALTH INFORMATION SAFE (PHI)		
	NE	CENTENE	Web: Member News	HEDIS	COL - Colorectal Cancer Screening	MEMBER		MEDICAID	2022	0						3/22/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	MARCH IS NATIONAL COLORECTAL CANCER AWARENESS MONTH		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Web: Member News	HEDIS,CAHPS	CAHPS - Access to Information,CBP - Controlling Blood Pressure,ADD - Follow-Up Care for Children Prescribed ADHD Medication	MEMBER		MEDICAID	2022	0						1/1/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Susan Jeffrey	QUALITY	WHOLE YOU MEMBER NEWSLETTER Q1		
	NE	CENTENE	Web: Member News	HEDIS,CAHPS	CAHPS - Access to Care,HDO - Use of Opioids at High Dosage,COU - Risk of Continued Opioid Use - 15 day rate,COU - Risk of Continued Opioid Use - 31 day rate,UOP - Use of Opioids from Multiple Providers	MEMBER		MEDICAID	2022	0						4/4/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Susan Jeffrey	QUALITY	WHOLE YOU MEMBER NEWSLETTER Q2		
	NE	CENTENE	Web: Provider News	CAHPS	CAHPS - Access to Information	PROVIDER		MEDICAID	2022	0						4/1/2022	12/31/2022	COMPLETED	Tim Easton	PROVIDER REL/ENG	Janelle Armstrong	MARKETING	SECURE PROVIDER PORTAL ENHANCEMENTS		
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022		0	0				1/6/2022	1/6/2022	Complete	Penny Parker	Marketing/Communications			Kearney Community Connections	35	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/6/2022	1/6/2022	Complete	Penny Parker	Marketing/Communications			Lincoln Early Childhood Network Support for Parents Meeting	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/7/2022	1/7/2022	Complete	Penny Parker	Marketing/Communications			Pandhandle Partnership Quarterly Meeting	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/12/2022	1/12/2022	Complete	Penny Parker	Marketing/Communications			Hall County Collaborative	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/12/2022	1/12/2022	Complete	Penny Parker	Marketing/Communications			North Platte Interagency	23	
	NE	Centene	Community support		Nutrition, Exercise	Member		Medicaid	2022							1/13/2022	1/13/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	7	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/18/2022	1/18/2022	Complete	Penny Parker	Marketing/Communications			Cass County Interagency	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/18/2022	1/18/2022	Complete	Penny Parker	Marketing/Communications			Refugee Health Collaboration	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/19/2022	1/19/2022	Complete	Penny Parker	Marketing/Communications			Grand Island Interagency	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/19/2022	1/19/2022	Complete	Penny Parker	Marketing/Communications			South Omaha Care Council	50	
	NE	Centene	Community support		Nutrition, Exercise	Member		Medicaid	2022							1/20/2022	1/20/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	8	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/20/2022	1/20/2022	Complete	Penny Parker	Marketing/Communications			Southwest CoC	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/20/2022	1/20/2022	Complete	Penny Parker	Marketing/Communications			Hastings Community Impact Network	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/20/2022	1/20/2022	Complete	Jamaree Maack	Marketing/Communications			Black Family Health & Wellness Association Meeting	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/25/2022	1/25/2022	Complete	Penny Parker	Marketing/Communications			Southeast CoC	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture	Member		Medicaid	2022							1/25/2022	1/25/2022	Complete	Penny Parker	Marketing/Communications			WCDHD Minority Health Taskforce	12	

Nebraska Total Care
2022 Interventions

	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture	Member		Medicaid	2022							1/25/2022	1/25/2022	Complete	Penny Parker	Marketing/Communications			Two Rivers Health Deparment Minority Health Taskforce	12	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/25/2022	1/25/2022	Complete	Jamaree Maack	Marketing/Communications			Fremont Family Coalition	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/26/2022	1/26/2022	Complete	Penny Parker	Marketing/Communications			Hastings Case Managers Meeting	8	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/26/2022	1/26/2022	Complete	Penny Parker	Marketing/Communications			Buffalo County Community Partners Collaboration	50	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							1/27/2022	1/27/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	8	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/2/2022	2/2/2022	Complete	Penny Parker	Marketing/Communications			Hastings Case Managers Meeting	20	
	NE	Centene	Community support	CAHPS	Childhood Nutrition/Obesity	Member		Medicaid	2022							2/3/2022	2/3/2022	Complete	Penny Parker	Marketing/Communications			Holiday Challenge - Fruit/Veggie Party	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/3/2022	2/3/2022	Complete	Penny Parker	Marketing/Communications			Kearney Community Connections	25	
	NE	Centene	Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/6/2022	2/6/2022	Complete	Penny Parker	Marketing/Communications			Children't's Day	750	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/7/2022	2/7/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/8/2022	2/8/2022	Complete	Penny Parker	Marketing/Communications			SCC Big Collaborative Quarterly Meeting	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/9/2022	2/9/2022	Complete	Penny Parker	Marketing/Communications			North Platte Interagency	20	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/10/2022	2/10/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	20	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/11/2022	2/11/2022	Complete	Penny Parker	Marketing/Communications			NEP Nutrition Education Series	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/15/2022	2/15/2022	Complete	Penny Parker	Marketing/Communications			Cass County Interagency	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care, Respect for culture	Member		Medicaid	2022							2/15/2022	2/15/2022	Complete	Penny Parker& Toni Webb	Marketing/Communications			Refugee Health Collaboration	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/16/2022	2/16/2022	Complete	Penny Parker & Toni Webb	Marketing/Communications			Immunize Nebraska	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/17/2022	2/17/2022	Complete	Penny Parker	Marketing/Communications			Southwest CoC	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/17/2022	2/17/2022	Complete	Penny Parker	Marketing/Communications			Hastings Community Impact Network	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/17/2022	2/17/2022	Complete	Penny Parker	Marketing/Communications			Central DD Advocacy Group Quarterly Meeting	8	

Nebraska Total Care
2022 Interventions

	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/21/2022	2/21/2022	Complete	Penny Parker	Marketing/Communications			Arc of Buffalo County - Parent Support Group	2	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture	Member		Medicaid	2022							2/21/2022	2/21/2022	Complete	Penny Parker	Marketing/Communications			Southeast CoC	10	
	NE	Centene	Interagency Collaboration- Cultural Competency training for community orgs	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture	Member		Medicaid	2022							2/21/2022	2/21/2022	Complete	Penny Parker	Marketing/Communications			WCDHD Minority Health Taskforce	12	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/21/2022	2/21/2022	Complete	Penny Parker & Toni Webb	Marketing/Communications			Families 1st Partnership Quarterly Meeting	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/21/2022	2/21/2022	Complete	Penny Parker	Marketing/Communications			Two Rivers Health Deparment Minority Health Taskforce	12	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							2/23/2022	2/23/2022	Complete	Penny Parker	Marketing/Communications			North Platte Project Connect Planning Meeting	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture, Access to care	Member		Medicaid	2022							3/1/2022	3/1/2022	Complete	Toni Webb	Marketing/Communications			Refugee Mental Health Committee Meeting	11	
	NE	Centene	Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/2/2022	3/2/2022	Complete	Penny Parker	Marketing/Communications			O'Connor Learning Center Health Fair	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/3/2022	3/3/2022	Complete	Penny Parker & Toni Webb	Marketing/Communications			Kearney Community Connections	25	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/3/2022	3/3/2022	Complete	Penny Parker & Toni Webb	Marketing/Communications			Lincoln Early Childhood Network Support for Parents Meeting	15	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture, Access to care	Member		Medicaid	2022							3/3/2022	3/3/2022	Complete	Toni Webb	Marketing/Communications			Refugee Health Collaborative Meeting	25	
	NE	Centene	Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022	$50.00						3/7/2022	3/7/2022	Complete	Penny Parker	Marketing/Communications			School Mental Health Conference	55	
	NE	Centene	Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/9/2022	3/10/2022	Complete	Penny Parker & Toni Webb	Marketing/Communications			Leading Edge Conference - Networking Event	200	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/9/2022	3/9/2022	Complete	Penny Parker	Marketing/Communications			North Platte Interagency	20	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/10/2022	3/10/2022	Complete	Penny Parker	Marketing/Communications			Vaccine Clinic	3	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/16/2022	3/16/2022	Complete	Penny Parker	Marketing/Communications			Grand Island Interagency	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/16/2002	3/16/2002	Complete	Toni Webb	Marketing/Communications			South Omaha Community Care Council Bimonthly Meeting	20	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/17/2022	3/17/2022	Complete	Penny Parker	Marketing/Communications			Hastings Community Impact Network	25	

Nebraska Total Care
2022 Interventions

	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/17/2022	3/17/2022	Complete	Toni Webb	Marketing/Communications			Black Families Health and Wellness	16	
	NE	Centene	Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/20/2022	3/20/2022	Complete	Toni Webb	Marketing/Communications			Early Childhood Family Fair	200	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/21/2022	3/21/2022	Complete	Penny Parker	Marketing/Communications			Arc of Buffalo County - Parent Support Group	5	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/22/2022	3/22/2022	Complete	Penny Parker	Marketing/Communications			Southeast CoC	10	
	NE	Centene	Interagency Collaboration	CAHPS	CAHPS- Rating of All Health Plans, Respect for culture, Access to care	Member		Medicaid	2022							3/22/2022	3/22/2022	Complete	Penny Parker and Toni Webb	Marketing/Communications			WCDHD Minority Health Taskforce	15	
	NE	Centene	Vision Van Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022	$4,000.00						3/25/2022	3/25/2022	Complete	Penny Parker, Toni Webb, Jamaree Maack, Janelle Armstrong	Marketing/Communications			Omaha Public School Independent Studies Health Fair	25	
	NE	Centene	Vision Van Event	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022	$6,000.00						3/26/2022	3/26/2022	Complete	Penny Parker, Toni Webb, Jamaree Maack, Janelle Armstrong	Marketing/Communications			Black Family Health & Wellness Health Fair	300	
	NE	Centene	Community support	CAHPS	CAHPS- Rating of All Health Plans, Access to Care	Member		Medicaid	2022							3/29/2022	3/29/2022	Complete	Penny Parker	Marketing/Communications			National Nutrtion Month Outreach- Agency on Aging	36	
	NE	CENTENE	Email Campaign	HEDIS	BCS - Breast Cancer Screening	MEMBER		MEDICAID	2022	0						4/5/2022	5/12/2022	COMPLETED	Janelle Armstrong	MARKETING	Amy Wing	Quality	Email Deploying: Breast Cancer Mammogram Bus event		
	NE	CENTENE	Email Campaign	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/11/2022	4/18/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Community Gardens		
	NE	CENTENE	Email Campaign	HEDIS	Covid-19	MEMBER		MEDICAID	2022	0						4/7/2022	5/10/2022	COMPLETED	Janelle Armstrong	MARKETING	Maria Martin	PHARMACY	Email Deploying: Covid-19 Booster Shots		
	NE	CENTENE	Email Campaign	HEDIS,CAHPS	CAHPS - Access to Care,HDO - Use of Opioids at High Dosage,COU - Risk of Continued Opioid Use - 15 day rate,COU - Risk of Continued Opioid Use - 31 day rate,UOP - Use of Opioids from Multiple Providers	MEMBER		MEDICAID	2022	0						4/13/2022	4/20/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Member Newsletter Q2		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						4/29/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Erica Anderson	Care Management	Email Deploying: Pregnancy Unknown		
	NE	CENTENE	Web: Homepage Feature	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/5/2022	7/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Home page feature: Community Gardens (value adds)		
	NE	CENTENE	Web: Member Event	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/12/2022	6/1/2022	COMPLETED	Janelle Armstrong	MARKETING			Member Events: Lawyers in the City		
	NE	CENTENE	Web: Member Event	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/12/2022	6/1/2022	COMPLETED	Janelle Armstrong	MARKETING			Member Events: Take control of your credit		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Web: Member Event	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/5/2022	6/1/2022	COMPLETED	Janelle Armstrong	MARKETING			Member Events: Tax Prep classes		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						5/2/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING			Member News: Access to Care for New Members		
	NE	CENTENE	Web: Member News	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/11/2022	10/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Community Gardens		
	NE	CENTENE	Web: Member News	SDOH	SDOH	MEMBER		MEDICAID	2022	0						4/25/2022	12/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Nebraska Homeowner Assistance Fund		
	NE	CENTENE	Web: Member News	HEDIS,CAHPS	CAHPS - Access to Care,HDO - Use of Opioids at High Dosage,COU - Risk of Continued Opioid Use - 15 day rate,COU - Risk of Continued Opioid Use - 31 day rate,UOP - Use of Opioids from Multiple Providers	MEMBER		MEDICAID	2022	0						4/4/2022	5/1/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Whole You member newsletter		
	NE	CENTENE	Text/SMS Campaign	HEDIS,CAHPS	CAHPS - Access to Care,HDO - Use of Opioids at High Dosage,COU - Risk of Continued Opioid Use - 15 day rate,COU - Risk of Continued Opioid Use - 31 day rate,UOP - Use of Opioids from Multiple Providers	MEMBER		MEDICAID	2022	0						4/13/2022	4/14/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Text Deploying: Member Newsletter Q2		
	NE	CENTENE	Web: Member News	SDOH	SDOH	MEMBER		MEDICAID	2022	0						5/2/2022	5/2/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Nebraska Homeowner Assistance Fund		
	NE	CENTENE	Email Campaign	HEDIS	COVID-19	MEMBER		MEDICAID	2022	0						5/4/2022	5/4/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: Covid 2nd Vaccine		
	NE	CENTENE	Email Campaign	HEDIS	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						5/5/2022	5/5/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APP Antipsychotic		
	NE	CENTENE	Email Campaign	HEDIS	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						5/9/2022	5/9/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APP Antipsychotic		
	NE	CENTENE	Web: Member News	HEDIS	CIS - Childhood Immunization Status	MEMBER		MEDICAID	2022	0						5/9/2022	5/9/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Childhood Immunizations		
	NE	CENTENE	Member Flyer	HEDIS	BCS - Breast Cancer Screening, CCS - Cervical Cancer Screening, CHL - Chlamydia Screening in Women	MEMBER		MEDICAID	2022	0						5/9/2022	5/9/2022	COMPLETED	Janelle Armstrong	MARKETING	Susan Jeffrey	QUALITY	Women's Health Screen Flyer updated		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						5/12/2022	5/12/2022	COMPLETED	Janelle Armstrong	MARKETING	Erica Anderson	POPULATION HEALTH	Email Deploying: Pregnancy Unknown		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						5/16/2022	5/16/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News post: Nationwide baby formula shortage		

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Staff Materials	HEDIS	PPC - Prenatal and Postpartum Care	HEALTH PLAN		MEDICAID	2022	0						5/16/2022	5/16/2022	COMPLETED	Janelle Armstrong	MARKETING	Kristi Goldenstein	POPULATION HEALTH	Perinatal Coaching Program branding (flashcards & facilitator guide)		
	NE	CENTENE	Member Flyer	CAHPS	CAHPS - Access to Information	PROVIDER		MEDICAID	2022	0						5/18/2022	5/18/2022	COMPLETED	Janelle Armstrong	MARKETING	Amy Wing	QUALITY	Foreign Language Poster for provider offices		
	NE	CENTENE	Email Campaign	HEDIS	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						5/19/2022	5/19/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APP Antipsychotic		
	NE	CENTENE	Web: Member News	CAHPS	CAHPS - Access to Care	MEMBER		MEDICAID	2022	0						5/23/2022	5/23/2022	COMPLETED	Janelle Armstrong	MARKETING	Adam Proctor	ADMIN OPS	Member News: Mobile Save to Apple Wallet		
	NE	CENTENE	Email Campaign	HEDIS	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	MEMBER		MEDICAID	2022	0						5/26/2022	5/26/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: APP Antipsychotic		
	NE	CENTENE	Email Campaign	HEDIS	ADD - Follow-up Care for Children Prescribed ADHD	MEMBER		MEDICAID	2022	0						5/27/2022	5/27/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: ADHD initiation		
	NE	CENTENE	Email Campaign	HEDIS	AMR - Asthma Medication Ratio	MEMBER		MEDICAID	2022	0						5/31/2022	5/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: AMR asthma action plan		
	NE	CENTENE	Email Campaign	HEDIS	BCS - Breast Cancer Screening	MEMBER		MEDICAID	2022	0						5/31/2022	5/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Email Deploying: BCS breast cancer		
	NE	CENTENE	Web: Member News	HEDIS	LSC - Lead Screening in Children	MEMBER		MEDICAID	2022	0						5/31/2022	5/31/2022	COMPLETED	Janelle Armstrong	MARKETING	Jamaree Maack	MARKETING	Member News: Lead Poisoning screening		
	NE	CENTENE	Email Campaign	HEDIS	PPC - Prenatal and Postpartum Care	MEMBER		MEDICAID	2022	0						6/2/2022	6/2/2022	COMPLETED	Janelle Armstrong	MARKETING	Erica Anderson	POPULATION HEALTH	Email Deploying: Pregnancy Unknown		
	NE	CENTENE	Care Coordination--5 VBC groups	CAHPS	CC - Care Coordination	PROVIDER		MEDICAID	2022	0	2		NE			1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	PROVIDER RELATIONS/ENG	Amy Wing	QUALITY	Care Coordination	Monthly meeting to discuss high utilizers of services, problematic discharge planning and continuity care. There is one care coordinator/health coach from Bluestem Health and OneWorld. CHI has at least 6 health coaches on the	NA
	NE	CENTENE	OB Record Project--NHN/CHI	HEDIS	PPC - Prenatal and Postpartum Care	PROVIDER		MEDICAID	2022	0	2		NE			1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Prenatal/Postpartum medical records	Monthly report submitted by NMC identifying and members that are pregnant.	NA
	NE	CENTENE	OB Record Project--NHN/CHI	HEDIS	PPC - Prenatal and Postpartum Care	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Prenatal/Postpartum medical records	Monthly report submitted by NMC identifying and members that are pregnant.	NA
	NE	CENTENE	SDS File --LMEP (Athena)	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File --Mary Lanning	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Beatrice	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Faith Regional	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA

Nebraska Total Care
2022 Interventions

	NE	CENTENE	SDS File Solicitation--Regional West	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	:Outreach and Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Bryan Health	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File Creation--Boystown	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	DELAYED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file solicitation	: Continue to work with CHI to get test file. Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Bluestem Health	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--CHI	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Charles Drew	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Great Plains	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Heartland Health Center	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Midtown Health Center	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Nebraska Health Network	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--OneWorld Community Health	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--SERPA	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	SDS File--Children Health Network	HEDIS	All HEDIS measures are collected from claim data	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	SDS Flat file submission	: Initial education about the SDS file related to needs and benefits. Ongoing support to ingest the file.	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes HbA1c < 8	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--CHI Clinics	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes HbA1c < 8	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bryan Health Network	HEDIS	CDC - Diabetes HbA1c < 8	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes HbA1c < 8	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Jefferson Community Health	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA

Nebraska Total Care
2022 Interventions

	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	CDC - Diabetes Care - Blood Pressure Control	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Blood Pressure Control	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	CDC - Diabetes Care - Eye Exam	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CDC - Diabetes Care - Eye Exam	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	CBP - Controlling Blood Pressure	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CBP - Controlling Blood Pressure	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	CCS - Cervical Cancer Screen - Pap Test	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CCS - Cervical Cancer Screen - Pap Test	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	BCS - Breast Cancer Screening	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	BCS - Breast Cancer Screening	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	Appropriate Testing for Pharyngitis-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Appropriate Testing for Pharyngitis-Total	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	Chlamydia Screening-Total	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Chlamydia Screening-Total	: Initial education provided, ongoing support to providers as needed	

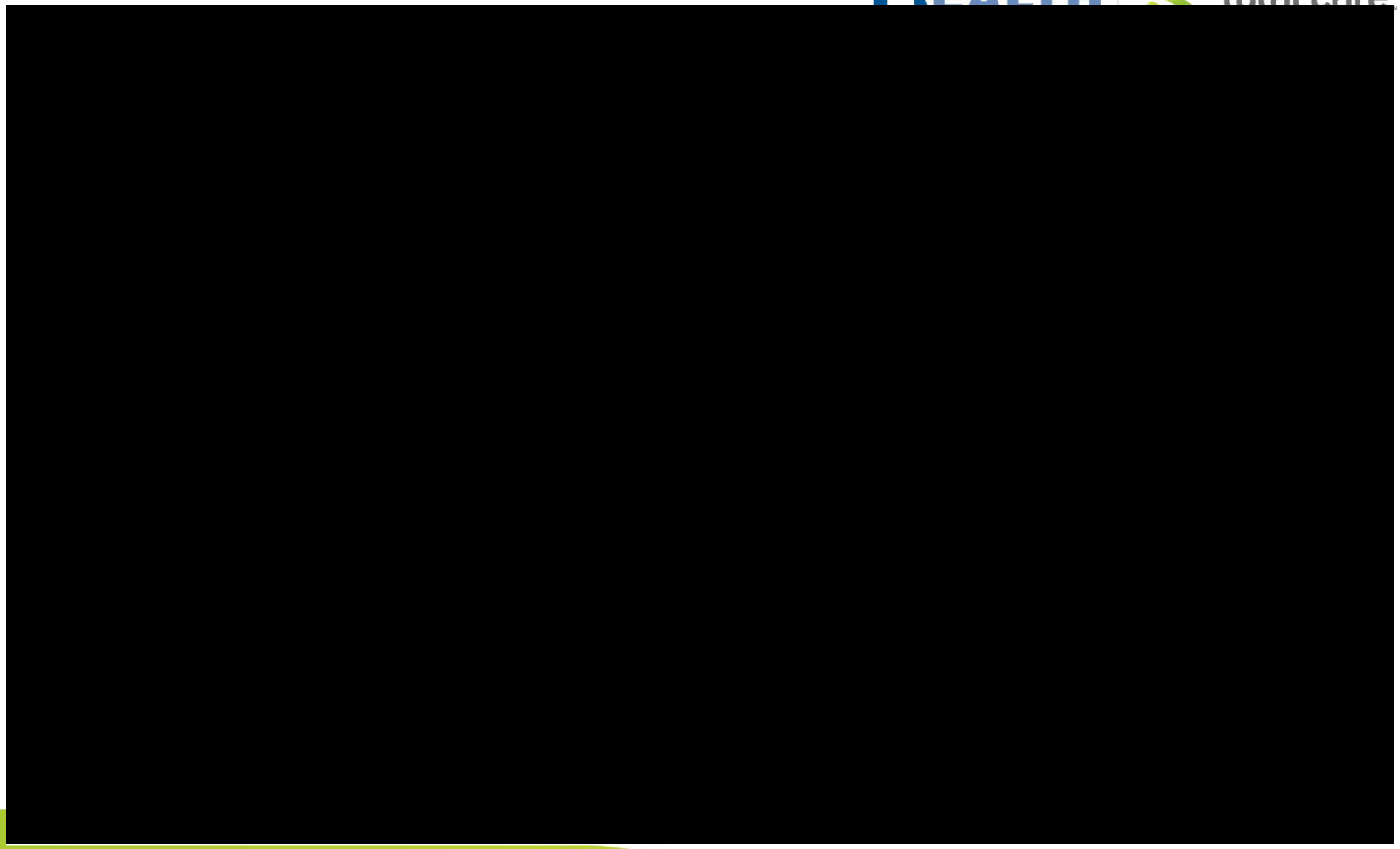
Nebraska Total Care
2022 Interventions

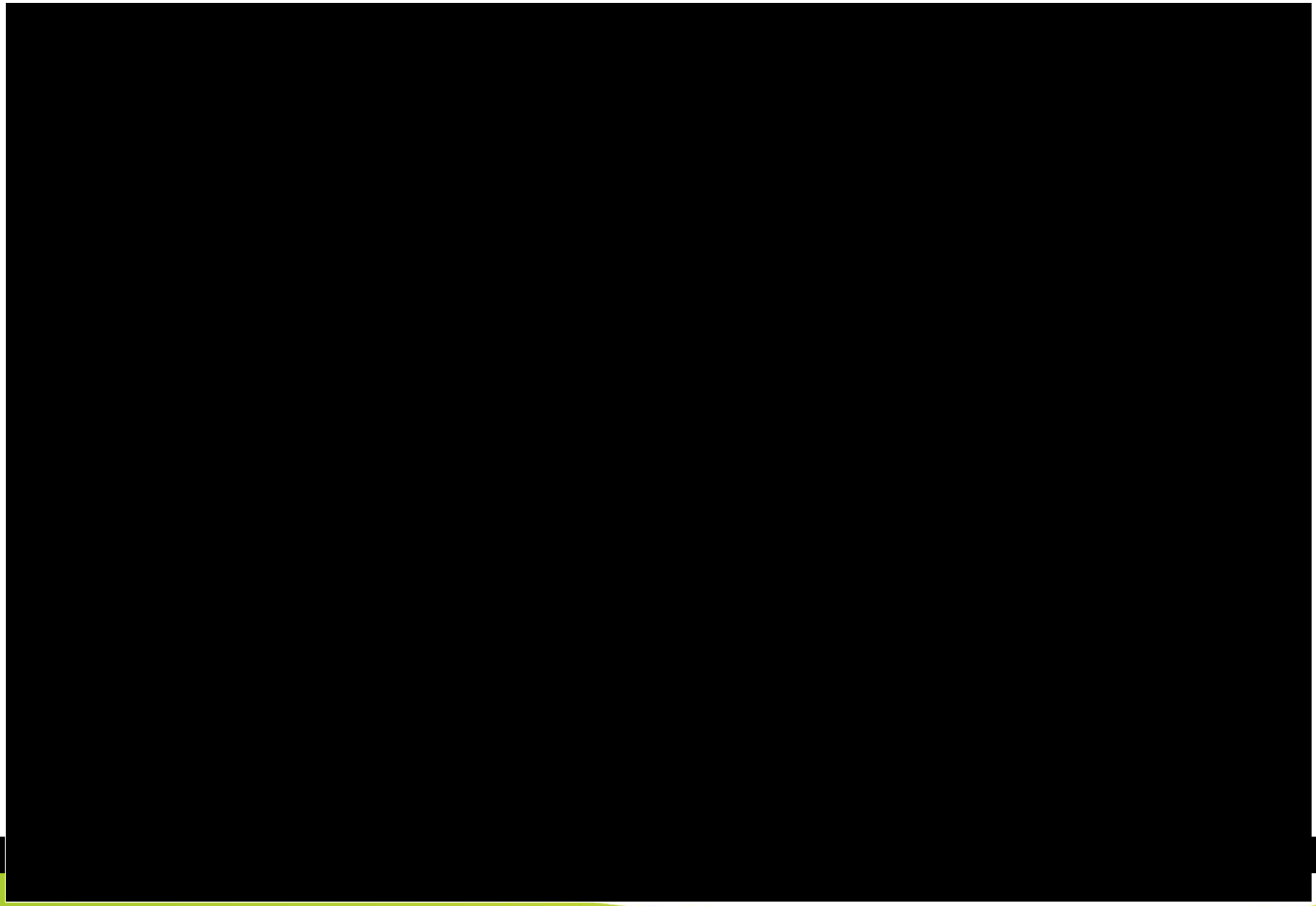
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	IMA - Adolescent Immunizations Combo 2	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	IMA - Adolescent Immunizations Combo 2	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	CIS - Childhood Immunization Status Combo 10	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	CIS - Childhood Immunization Status Combo 10	: Initial education provided, ongoing support to providers as needed	NA
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	WCC - Weight Assessment and Counseling - BMI	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - BMI	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	WCC - Weight Assessment and Counseling - Nutrition	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Nutrition	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	WCC - Weight Assessment and Counseling - Physical Activity	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	WCC - Weight Assessment and Counseling - Physical Activity	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	Well-Child Visits in the First 15 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits in the First 15 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	Well-Child Visits for Age 15-30 Months	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Well-Child Visits for Age 15-30 Months	: Initial education provided, ongoing support to providers as needed	
	NE	CENTENE	Provider Education--Bluestem Health	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely	
	NE	CENTENE	Provider Education-Bryan Health Network	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely	
	NE	CENTENE	Provider Education--CHI	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely	
	NE	CENTENE	Provider Education--Children's Health Network	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely 6-10 people attend from the provider	
	NE	CENTENE	Provider Education--Great Plains Health	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely	
	NE	CENTENE	Provider Education--Nebraska Health Network	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely 6-10 people attend from the provider	
	NE	CENTENE	Provider Education--OneWorld Community Health	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely 6-10 people attend from the provider	
	NE	CENTENE	Provider Education--SERPA Clinics	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Monthly VBC or JOC meetings	Provider gap closure status, scoring and discussion to help with HEDIS measures. Best Practices are shared at these monthly meetings. Routinely	
	NE	CENTENE	Provider Education--Lincoln Family Medicine	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Provider Education	Provider education on measures that are on the P4P list	
	NE	CENTENE	Provider Education--Kimball Clinic X 2	HEDIS	All measures on QPP and P4P program	PROVIDER		MEDICAID	2022	0	2					1/1/2022	12/31/2022	STARTED	Laurie Krause/Jennifer Newcombe	ADMIN/OPS	Amy Wing	QUALITY	Provider Education	Provider education on measures that are on the P4P list	

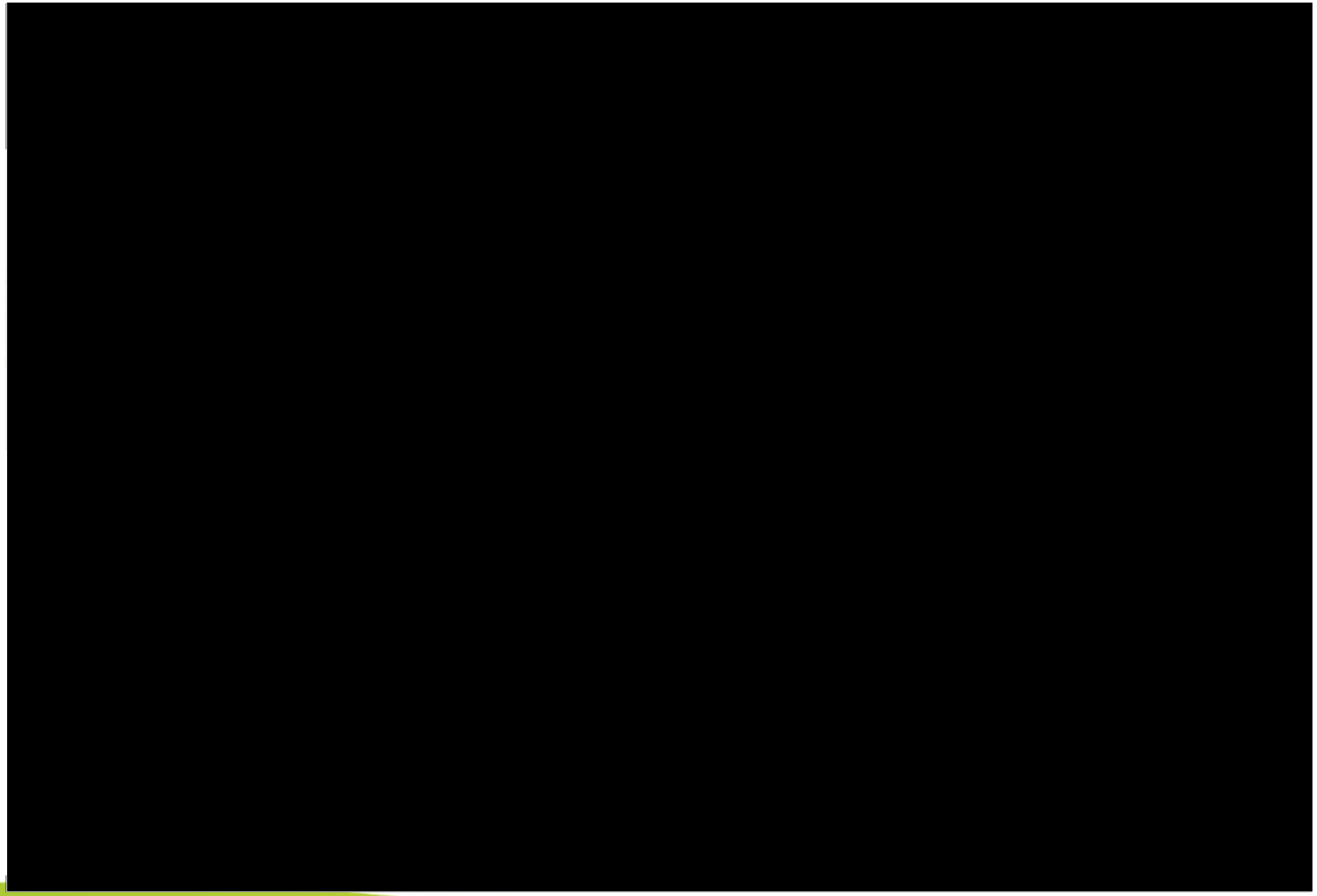
RFP 112209 O3

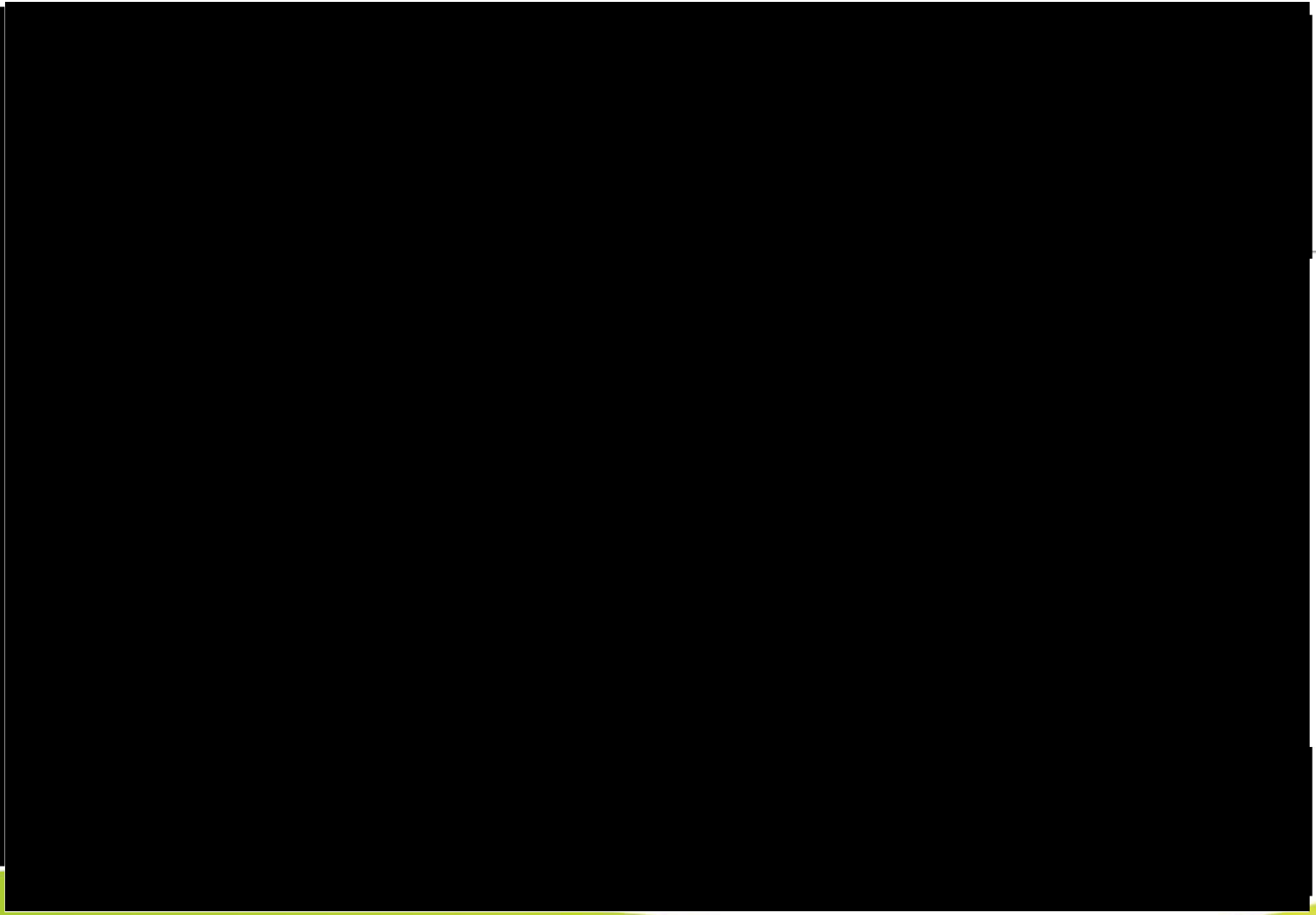
Attachment B.74
Sample Provider Reports

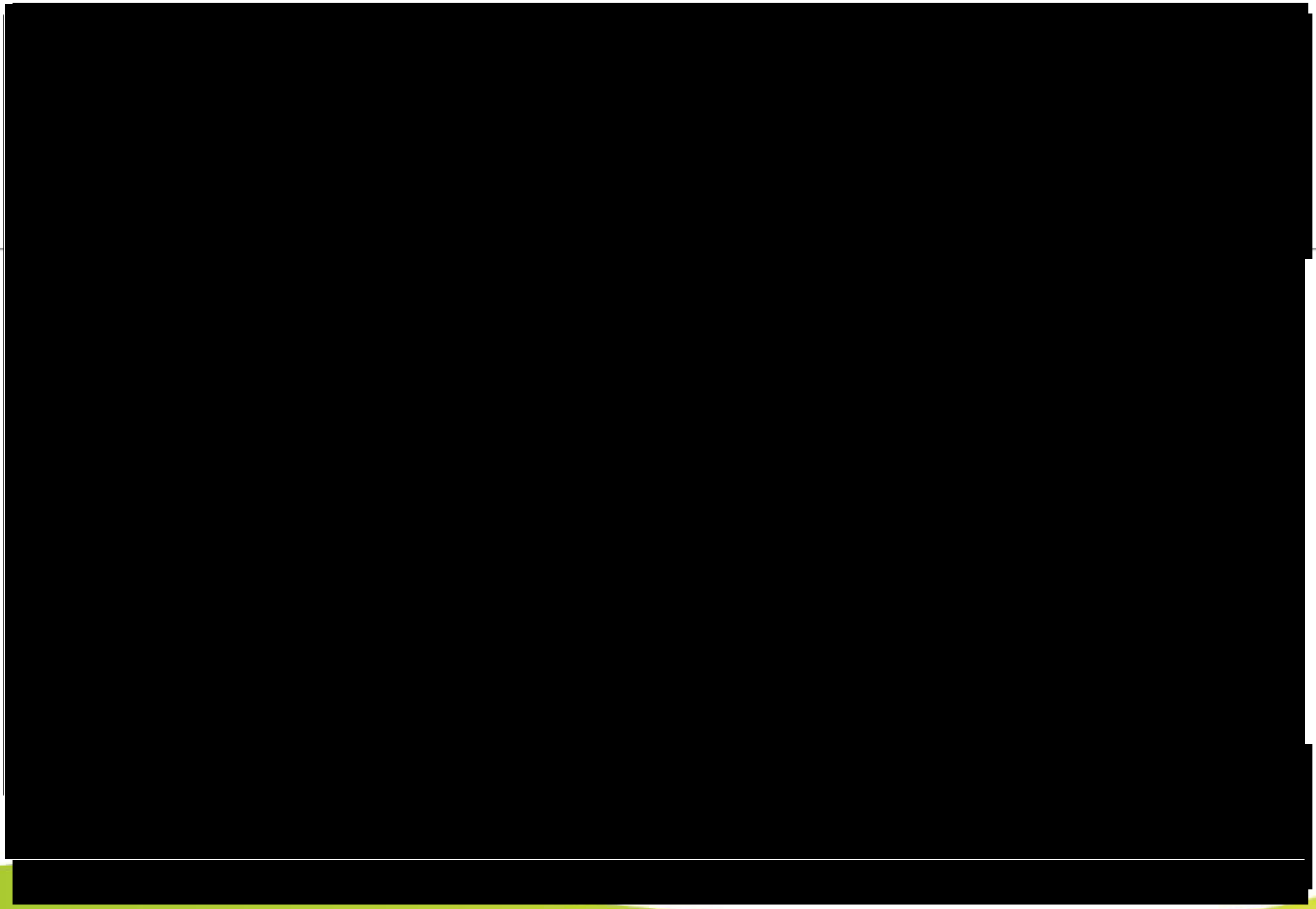
Provider Profile Report

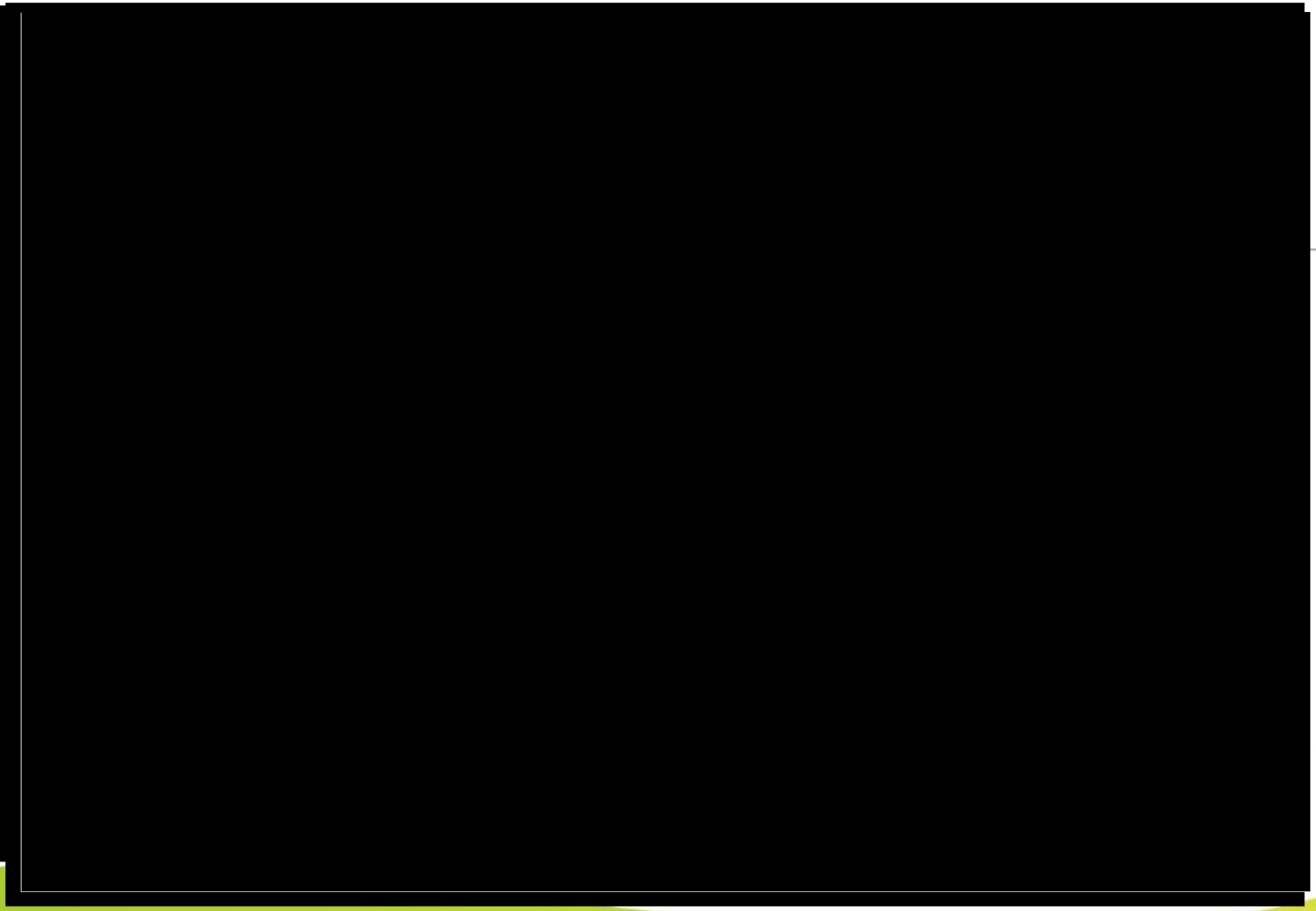


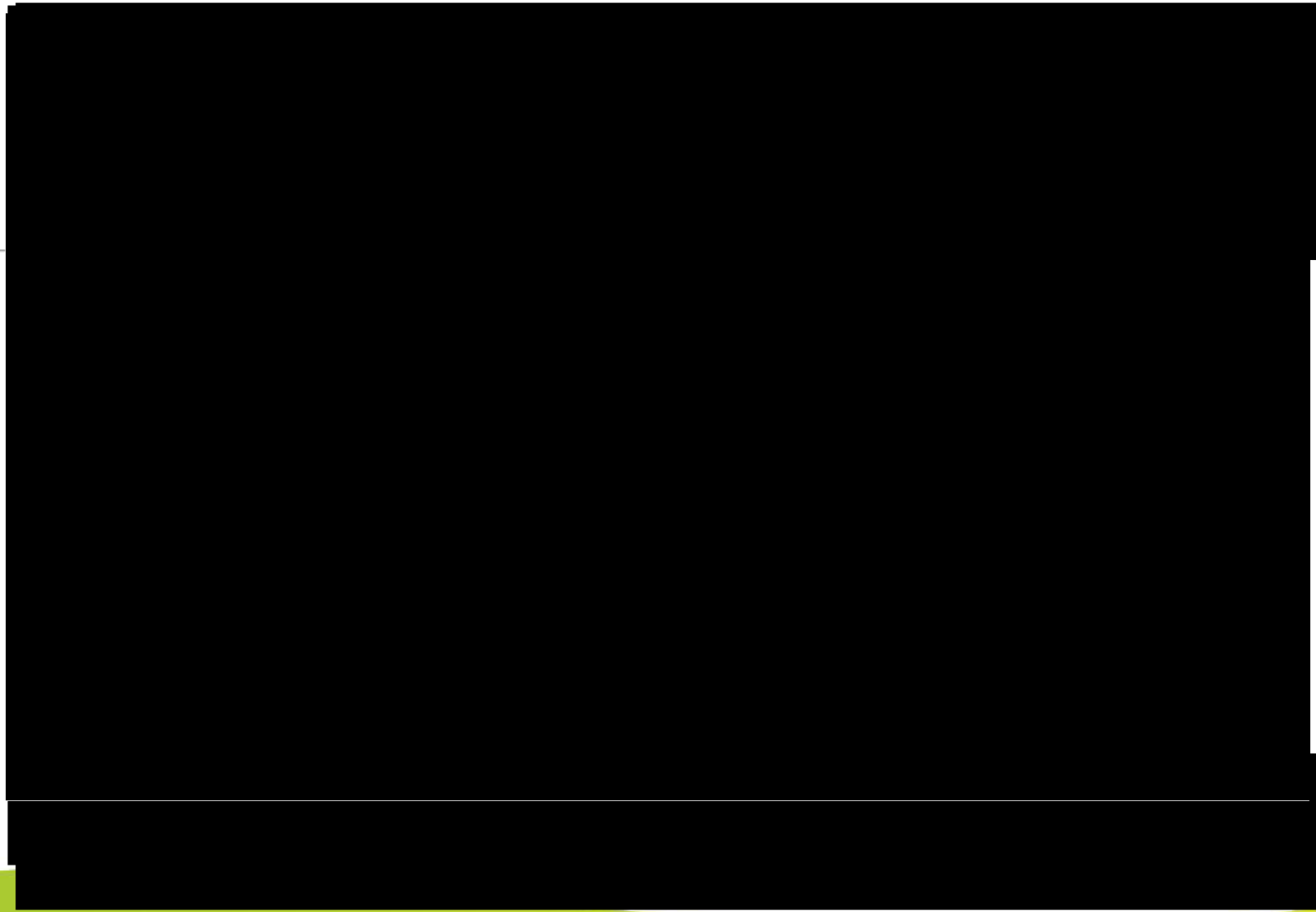


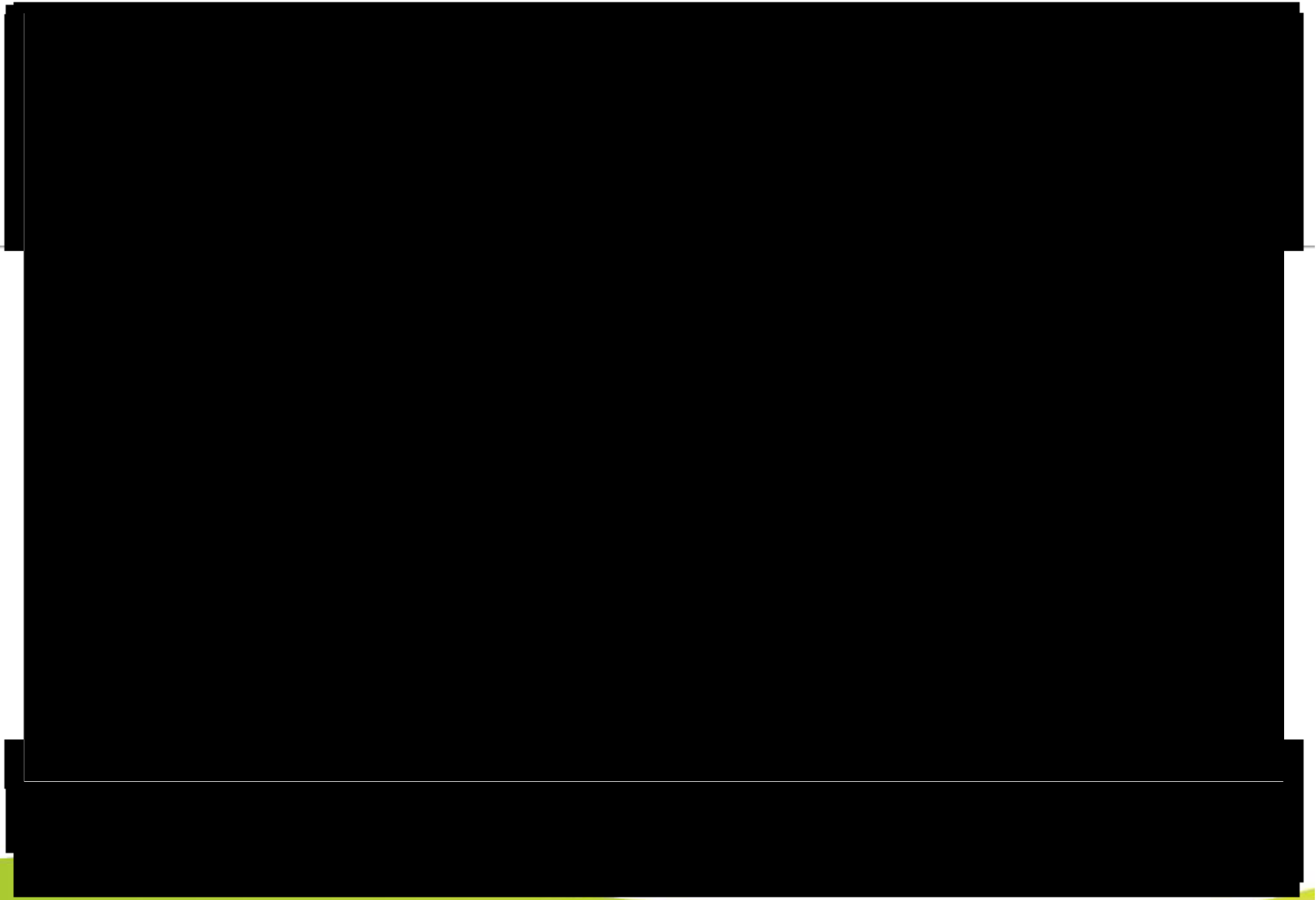


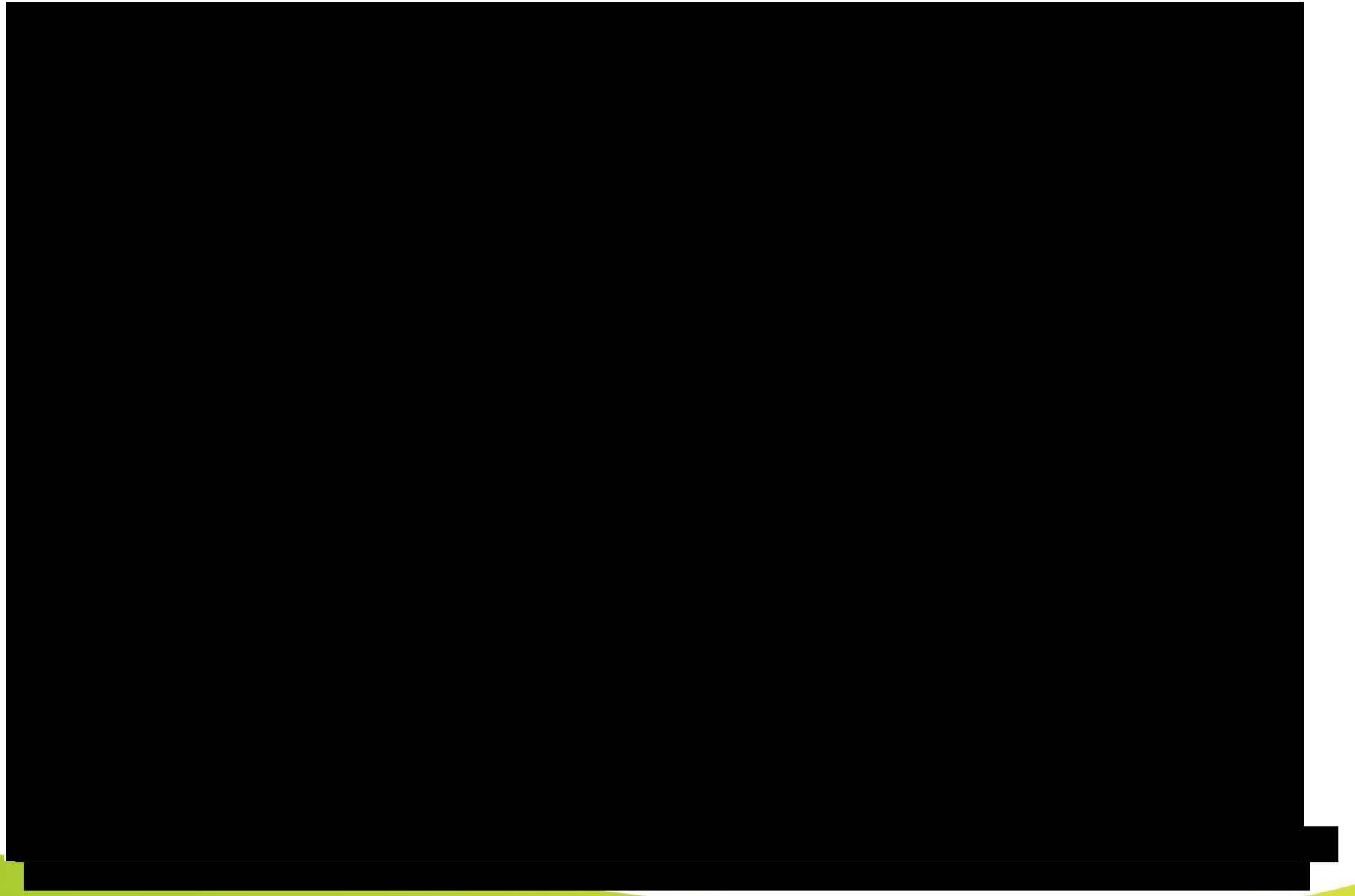












RFP 112209 O3

B. Technical Approach

V.N Utilization Management

V.N Utilization Management

77. Describe the Bidder's approach to utilization management, including:
• Innovations and automation the Bidder will use for its UM program.
• Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers.
• Mechanisms to detect and document over- and under-utilization of medical services.
• Processes and resources used to develop and regularly review utilization review criteria.
• The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated.
• Describe what will be considered in the reevaluation of the need for ongoing prior authorization requirements.
• The proposed prior authorization processes for members requiring services from non-participating providers
The proposed processes for expedited prior authorization.
Page Limit: 10

Nebraska Total Care has managed utilization for Heritage Health since 2017 and currently serves more than 120,000 members statewide. We combine our local knowledge and experience with the proven Utilization Management (UM) approaches, innovative programs, best practices, and sophisticated technology resources of our parent company, Centene Corporation (Centene). Centene is a national leader in health services and brings over 38 years of experience providing programs and services to individuals receiving benefits through Medicaid and other government-funded programs. Centene currently manages and oversees utilization for over 15 million Medicaid Members across 29 states. Since the program's inception, Nebraska Total Care's NCQA-compliant UM program has evolved from a linear focus on medical necessity to a broader, more member-centric approach that improves health outcomes, health equity, member experience, and efficiency and effectiveness.

The goals of our UM program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. Our UM mission is to ensure members receive clinically appropriate services in the least restrictive level of care while improving health and quality of life for all.

Our Nebraska-based and Nebraska-licensed Chief Medical Officer (CMO), Dr. Chris Elliott, has operational responsibility for and provides support to Nebraska Total Care's UM Program. Dr. Elliott is a board-certified physician with more than 30 years of experience in physical health (PH) and emergency department (ED) service delivery and leadership in Nebraska. Dr. Elliott develops, implements, and interprets medical policies and procedures and oversees service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals. The CMO and Vice President of Population Health and Clinical Operations are the senior executives responsible for implementing the UM Program. They are responsible for cost containment; reviewing activities on utilization review, complex, controversial, or experimental services; and successful operation of the UM Committee (UMC). Our CMO is supported by other Nebraska-based and Nebraska-licensed Medical Directors. Our BH Medical Director, Dr. Wendy Welch, implements, monitors, and directs the BH aspects of the UM Program. Dr. Welch is a Certified Physician Executive with more than 20 years of experience across psychiatry, Behavioral Health (BH), addiction, and PH care environments and is triple boarded by the American Board of Psychiatry, Child and Adolescent Psychiatry, and Addiction Psychiatry. Our Pharmacy Director oversees pharmacy services, and our new Dental Director will participate in the implementation, monitoring, and directing of dental health-related services. Program Specialists coordinate psychosocial and community resources and assist members with the utilization of medical resources related to Care Management, disease management, and discharge planning. We submit our UM Program Description to MLTC for approval annually, which minimally encompasses all topics as required in SOW N.2.

Satisfaction with UM Processes

Nebraska Total Care's overall provider satisfaction **improved 3 years in a row, and far exceeds other Nebraska health plan's ratings**. UM related satisfaction rates include education related to changes in PA was clear and timely rated **82%**; and satisfaction with the payment authorization process rated **82%**.

Level I Review. Prior authorization clinical staff, including PH and BH nurses, physical therapists, speech therapists, and occupational therapists, trained in the principles, procedures, and standards of utilization and medical necessity conduct Level I UM reviews using TruCare Cloud, our integrated care and utilization management platform. TruCare Cloud uses InterQual's clinical determinations platform to enable real-time determinations of medical necessity, manage PAs, and support concurrent reviews, discharge planning, and transition service reviews. For dental PAs, a hygienist from our subcontractor, Envolve Dental, Inc. will review requests based on dental medical necessity criteria. UM clinical staff also consider the individual member's needs and situation, for example, the member's age, co-morbidities, complications, the

progress of treatment, psychosocial situation, and home environment) at the time of the request, in addition to the local delivery system available for care. ***At no time does a Level I review result in a reduction, denial, or termination of service. Only a Nebraska Total Care Medical Director can make an adverse determination during a Level II review.***

Level II Review. Nebraska Total Care uses a peer review process for Level II reviews when a Level I review indicates the request does not meet medical necessity criteria for a certain type of care. ***Specialty-matched peer review increases the efficiency of the review process by having an impartial subject matter expert in the specialty make standards-based recommendations for the Medical Director's consideration.*** For example, a BH service is reviewed by a Nebraska-licensed BH practitioner who then forwards their recommendation to a BH Medical Director for final consideration. We also use licensed occupational, speech, and physical therapists for Level II peer reviews of these therapy services. To support integrated dental services, a licensed dentist from Envolve Dental, Inc. will review dental PAs and make recommendations to Nebraska Total Care's Dental Director.

Nebraska Total Care Exceeds Timeliness Standards

We complete standard authorization reviews in an average of **5 days**, less than half the required 14 days. In 2021, we processed **99%** of standard authorizations within the required timeframe for both PH and BH requests.

Requests automatically sent for Level II review include requests for services or procedures that require benefit determination and services that do not have existing medical necessity criteria or are potentially experimental or new in practice. When the request does not meet the existing medical necessity criteria following a Level I review, the review moves to a Level II. All Level II reviews consider continuity of care, individual member needs at the time of the request, and the local delivery system available for care.

Innovations and Automation in our UM Program

Since 2017, Nebraska Total Care has brought innovation and automation to support medically necessary care, consistent application of guidelines, and monitoring and intervention for under and overutilization. We will continue to simplify processes to reduce provider administrative burden and ensure a seamless system of care. Our innovations and automation are rooted in TruCare Cloud, our Care Management, and UM platform. TruCare Cloud provides Care Managers and UM staff access to real-time member, provider, and electronic health record (EHR) data. This integration improves the speed and accuracy of the authorization process, resulting in improved member and provider experiences and better health outcomes. TruCare Cloud integrates with our Nurse Advice Line so information, referrals, and follow-up actions are delivered to the member's Care Manager for a more holistic picture of a member's health, including data on PH, BH, dental and pharmacy. Our flexible systems will allow for easy incorporation of dental and non-Medicaid service data. Backed by TruCare Cloud, our integrated family of innovative technologies to support administrative productivity through automation, clinical quality, and operational efficiency include:

- **Pre-Auth Check Tool**. Our website offers access to an automated prior authorization check tool. Providers can submit requests for PA and inpatient certification by phone, fax, or through our secure Provider Portal after verifying that PA is required.
- **Auth Digital Assistant**. On June 1, 2022, we launched our Auth Digital Assistant to augment automated authorizations, which is a machine learning technology that leverages years of historical and constantly updated PA review outcomes history. It automatically examines all submitted PA requests to identify which ones can be instantly approved. It considers the provider, procedure, practice, patients, and other characteristics of a particular PA, as compared to our model database of historical PAs. The Auth Digital Assistant self-audits through machine learning continual calibration and relieves PA requirements for providers based on an algorithm.
- **InterQual Connect™ (IQC)**. Nebraska Total Care enhanced our web-based authorization capability through the implementation of InterQual Connect™, a point-of-care solution in our secure Provider Portal. InterQual Connect™ streamlines the authorization process by incorporating InterQual criteria in an automated, interactive workflow that supports real-time medical appropriateness review and determination for key services. This interactive workflow uses auto-determination rules to approve or pend PA requests, providing a timely response to providers via our secure Provider Portal and reducing overall turnaround time on authorizations. Using InterQual Connect™ on the Provider Portal, providers can track their PA submissions, enhancing practice management by allowing providers to deliver organized, clinically informed, and technology-supported care to members.

Streamlining Approval Processes

InterQual Connect™, available through our Provider Portal, incorporates InterQual criteria in a fully automated, interactive workflow that provides a real time determination for select services.

- **Advanced EHR Integration**. We are conducting an Advanced ***EHR Integration pilot in collaboration with Methodist facilities, Bryan Medical Center, and Children's Hospital*** to support providers with the submission, tracking, and determination of PAs within their EHR systems. We will leverage our Clinical Data and Interoperability Gateway and strategic national partnerships to enhance our data sharing capabilities through bi-directional exchange with Provider EHR platforms. Expanded interoperability capabilities using FHIR, EHR proprietary APIs, HL7, and other standards allow us to automate the extraction of EHR data and deliver insights back into EHRs at the point of care. This bi-directional data exchange with alerts directly within the Provider's existing workflow will greatly improve efficiency and enable them to conduct targeted outreach for quality improvement. This data will be fed to our Real-Time Repositories (RTRs) so we can expediently share data with care teams via our TruCare Cloud. From there, this data will be integrated into our Enterprise Data Warehouse (EDW) where it will be used for analytic and reporting purposes, along with all the existing clinical and administrative data we integrate into EDW today. This additional EHR data will enhance our support for concurrent review, discharge planning, HEDIS data collection, care gap closures, clinical quality improvement, and grievance and appeal process support.
- **Admission, Discharge, and Transfer (ADT) transactions**. Through our ***Clinical Data and Interoperability Gateway, we connect with CyncHealth to ingest ADT data***. We will continue to encourage providers to use EHRs and CyncHealth for data submission (quality metrics, assessments, and SDOH information), ADT data, and data and information to support our quality initiatives (care gap closures) and Care Coordination teams. We are enhancing our use of ADT data loaded automatically into TruCare Cloud by creating pre-populated inpatient authorization review requests for our UM staff to process and complete. We are introducing new integrated workflows in support of ***ED Hospital Event Notifications***, using feeds of real-time ADT transactions to automatically create a task for appropriate CM follow-up to start discharge planning. We have enhanced our Provider Portal to show recent member ADT data to provide insight for provider intervention.
- **Provider Portal**. Our secure Provider Portal allows providers to submit requests for prior authorization (PA), concurrent review, and retrospective review. ***Through the portal's online authorization request and status feature, providers can submit and check the status of authorization requests (approved, denied, pending).*** The portal supports automation including the population of member data based on entered identifiers, and smart editing that enforces referential integrity rules on the data the provider enters to reduce errors. Requests entered via the portal generate a request record in TruCare Cloud, which UM staff review and triage for timely review and determination. We currently accept claims-related appeals through the Provider Portal, and building on our continuous efforts to support providers, we are enhancing the Provider Portal to enable providers to submit requests for Peer-to-Peer consultation with a Medical Director and submission of appeals of adverse benefit determinations by Contract start date.

Nebraska Total Care's High Provider Portal Adoption

Nebraska Total Care providers appreciate our Provider Portal, with a **41% adoption rate**, 4th highest among all Centene plans across the Country, and an average **40% rate of electronic PA** submissions in 2021.

- **Dental Services Platform.** Our delegated dental vendor, Envolve Dental, Inc. (Envolve), will make its proprietary information management system available to dentists and specialty dental providers to submit authorization requests and claims electronically. Envolve will share their UM data and claims information with Nebraska Total Care daily to provide staff an integrated, whole health view of members' PH, BH, dental, and pharmacy services to ensure coordination of care. Envolve will provide Nebraska Total Care with a monthly dashboard report for monitoring service level agreement compliance.

UM Program Policies and Procedures and Consistent Application of Clinical Criteria

UM Program Policies and Procedures. Nebraska Total Care's Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees the development, implementation, and evaluation of the Quality Assurance Performance Improvement (QAPI) Program. The BOD delegates the daily oversight and operating authority of UM Program activities to the Plan's QAPI Committee, which, in turn, delegates responsibility for the UM Program to the Utilization Management Committee (UMC). The UMC is responsible for the review and approval of medical necessity criteria and protocols, and UM Program policies and procedures. The UMC is responsible for reviewing all UM issues and making recommendations to the Plan's QAPI or the BOD, as necessary. Our BOD and QAPI Committee review and approve the UM Program annually.

Developing. Nebraska Total Care's suite of UM policies and procedures are compliant with current NCQA Health Plan Accreditation UM criteria, applicable State and Federal UM guidelines, and all contract requirements per Section V.N Utilization Management. The UMC and QAPI Committee are responsible for the review and approval of medical necessity

criteria and UM policies and procedures, including annual reviews and periodic updates to incorporate changes in standards or guidelines. We include practitioners representing the range of providers within the network on our committees to participate in the development of UM policies and procedures.

Implementing. We submit all written policies and procedures to MLTC for approval as required per SOW C. Business Requirements, 11. Written Policies and Procedures. Per NCQA standards, we post all UM policies and procedures on our website. The CMO and VPPHCO ensure the implementation of UM policies and procedures through appropriate posting, training, education, and auditing, per the UM Program Description. This includes initial and ongoing training of staff, members, and providers, in coordination with other departments. For example, Provider education covers all aspects of our UM Program, such as medical necessity criteria and guidelines; clinical practice guidelines; PA requirements and processes; forms and instructions; determination timeframes; and grievance, appeal, and State Fair Hearing processes. Members can access PA information through the website, Member Portal, and Member Handbook.

Monitoring. The UMC monitors and analyzes relevant data to evaluate the appropriate implementation and impact of UM policies and procedures quarterly, including impact on health care services, coordination of care, and appropriate use of services and resources. We report this analysis and the status of any corrective action plans to the QAPI Committee quarterly. Our Medical Management Coordinator monitors compliance with UM policies and procedures through our auditing processes. For example, they audit policies and procedures against contract requirements and PA reviews, pulling random samples to ensure the policies and procedures are followed. They monitor turnaround time reporting for compliance with timely notifications. Annually, we complete a Medicaid UM Evaluation per NCQA, including a review of the effectiveness of the UM program policies and procedures, and an internal audit by our Compliance department to validate policies and procedures implementation and alignment with the Contract.

Consistent Application of Criteria. Part of ensuring appropriate utilization of services is ensuring our staff is well trained and aligned, adhering to standard decision-making criteria. All UM staff use clinical decision criteria, such as InterQual and local clinical policies, to determine medical necessity in alignment with the State's definition. Clinical review criteria are based on nationally recognized criteria reflecting evidence-based clinical practice, along with State program requirements. The criteria that drive our UM decisions are embedded within TruCare Cloud. We do not reward practitioners or other individuals for issuing denials of coverage or care, and there are no financial incentives for UM decision-makers to deny or restrict care.

Clinical Decision Making. Our CMO, in partnership with the BH Medical Director, Dental Director, and Vice President of Population Health and Clinical Operations, is accountable for individual medical necessity determinations. This includes ensuring consistent application of criteria, oversight of UM staff training, measuring performance against standards, such as timeliness of decision-making and notifications, and consistent application of clinical guidelines. The CMO, with support from Centene corporate training and Inter-rater Reliability (IRR) Auditing, is responsible for training and supervision of Medical Directors and other physician consultants related to UM activities. Adverse determinations can only be made by a Medical Director or other health care professional as appropriate.

Staffing with Integrity. Nebraska Total Care does not incentivize staff to deny, limit, or discontinue services. We strictly follow State licensure guidelines to ensure determinations are only made by licensed clinical professionals, with appropriate clinical expertise, who are in good standing with no history of disciplinary action. Nebraska Total Care staff who support the UM process have no history of disciplinary actions with their licensing board. If disciplinary action should occur, we will remove these staff from the UM team.

UM Staff Training and Oversight. We train UM staff on UM criteria, policies, and protocols on an annual and ad hoc basis. We perform quarterly audits. Staff training includes Single Case Agreement (SCA) requirements and workflows. We train upon hire and throughout the year as we identify opportunities for improvement or changes. Through our internal oversight process, including IRR assessment, case review, physician peer review, and UMC review, we ensure utilization and coverage decisions are appropriate, consistent, and standardized with these criteria and policies.

Multidisciplinary Rounds. Our UM staff participates in inpatient rounds with Medical Directors and Care Managers. During rounds, the team reviews our inpatient census and discusses specific cases, including BH inpatient and NICU cases. This case-specific discussion facilitates shared understanding and discovery of differences or misunderstandings that we vet through the rounds process. UM staff participate in Care Management's multidisciplinary care team rounds. This group learning facilitates a review of our processes as we strive for continuous improvement in delivering UM services to members and providers.

IRR Auditing. All new UM employees, Medical Directors, and other individuals with decision-making responsibilities undergo IRR evaluation within 90 calendar days of initial InterQual training. Evaluation and assessment processes are

consistent with NCQA UM accreditation standards. They allow us to identify areas of challenge, subsequent training opportunities, and/or policy or process modifications. If any staff score <90%, they must retrain and successfully retest within 30 days. Inability to pass retesting/audit review is subject to further action up to or including termination. The same approach for IRR is applied annually and following NCQA guidelines to all clinicians responsible for performing UM or clinical appeal reviews. Physician and therapist peer review discussions occur three times per year and are overseen by the CMO. Ongoing, real-time validation of criteria application occurs during inpatient rounds (three times per week). **Table 77.A** demonstrates our 2021 IRR testing results. ***From 2020 to 2021, our initial testing scoring averages overall improved from 92.3% to 96.5% for PH; and from 98.6% to 100% for BH. Envolve Dental 2021 Annual Interrater Reliability audit resulted in an overall score of 92%.***

Table 77.A 2021 IRR testing results demonstrate high consistency in the application of clinical criteria across our staff.

Physical Health Testing Category	IRR Testing Initial Testing Results	IRR Retesting Results
Acute Adult	86%	100%
Acute Pediatric	100%	100%
Procedures Criteria	100%	100%
Rehabilitation Criteria	100%	100%
Subacute & SNF Criteria	100%	100%
Molecular Diagnostic Criteria	86%	100%
Behavioral Health Testing Category	**IRR Testing Initial Testing Results**	**IRR Retesting Results**
Behavioral Health InterQual	100%	100%
American Society of Addiction Medicine Criteria (ASAM)	100%	100%

Nurse to MD Monitoring Dashboard. In June 2022, we are launching a new ***Nurse to MD Dashboard*** to monitor the consistent application of criteria by individual clinical reviewers, including alignment of nurse to Medical Director decision-making and referral patterns for prior authorization and concurrent review UM staff. The dashboard will allow drill down to the staff level on decision-making and referral patterns and comparison to peers and industry standards to identify opportunities for staff education.

Physician Reviews. Annually and as needed, Centene's Medical Management Audit (MMA) department reviews decisions by our Nebraska Medical Directors to determine accuracy and consistency. Medical Directors from Centene plans across the country review decisions made by their peers and provide a rationale for their evaluation. Outcomes from audits may result in training or process improvements. We further ensure physician consistency through quarterly IRR reviews by Centene's MMA Department of Medical Directors across affiliate plans in specific regions. Our Medical Directors discuss cases (including denials) twice monthly and ad hoc medical staff meetings to improve consistency.

Detecting and Tracking Over and Underutilization

A key function of UM is the identification of Nebraska Total Care's Centelligence reporting and analytics platform includes dashboards, reports, and analytics tools to monitor and analyze over- and underutilization. Centelligence tracks data by race/ethnicity, diagnosis, subpopulations, and geography (urban/rural/frontier) so we can tailor interventions to specific members or regions. With oversight from our CMO, Quality, Pharmacy, Population Health, Case Management, and UM departments, staff review and analyze Centelligence reports. Through these reports, generated daily, weekly, monthly, quarterly, and annually, we can identify patterns of over- and underutilization and opportunities for intervention and improvement. Examples of reports include ED trend reports; medical and BH services encounter reports; pharmacy, vision, and dental reports; BH medication management reports; readmission reports; HEDIS dashboards; and members without a Primary Care Provider (PCP) visit report. This evaluation includes root cause analysis to identify underlying reasons for the utilization pattern. It can result in the identification of needed clinical practice guidelines and other interventions such as educational programs, outreach initiatives, and incentive programs.

Health Equity Neighborhoods

Described in detail in response to Question 89, our new Health Equity Neighborhoods will generate tailored interventions in specific zip codes to addressing disparities through hyper-focused community-wide engagement.

Our predictive analytics leverages internal, publicly available, and external data, and applies data science and analytic techniques to assess a member's risk for developing a particular disease or health outcome, utilization of emergency services or inpatient admission, or their likelihood of taking a certain action (for example, engaging with our Care Managers). Our staff uses our predictive analytics to identify, prioritize, and outreach to members for Care Management and enrollment into clinical programs.

Nebraska Total Care has systems and processes to identify over- and underutilization of services at the provider/practice level. Our UMC establishes utilization thresholds, evaluates trends, and acts upon outlier behavior. They develop a corrective action plan within 30 days of an identified issue and approve it at the next scheduled UMC meeting. If necessary, they may review issues that involve specific providers who are subject to peer review within our Credentialing Committee.

Underutilization. To detect underutilization, we monitor access to preventive care in addition to performing a monthly review of HEDIS measures. We have enhanced our quality program by improving our ability to deliver prospective care gap analytics to our staff and providers. ***Care gap information is recomputed and updated in near-real-time***, compared to the traditional weekly or monthly cycles, significantly improving our staff and providers' ability to address member care gaps and close them quickly. Available to Care Managers through TruCare Cloud, and to providers through our secure Provider Portal and the Availity Essentials™ Multi-Payer Portal, users can view care gap data at the member, provider, and practice levels, with drill-down functionality for member-specific and clinical details. Users can analyze care gap alerts using clinical reasoning; HEDIS reasoning; and all clinical evidence, such as relevant data sources. This helps users understand the interventions needed to close member care gaps within a single source. Our capabilities are part of our overall strategy to use near-real-time analytics to create a forward-looking health roadmap for members wherein staff and providers can identify and address emerging health issues at the earliest, most clinically appropriate time, before they become significant health conditions.

We analyze service utilization data, referrals, PAs, and claims data (including historical claims if a member is new) to identify gaps in care that reveal SDOH barriers. One of the ways we do this is through our ***SDOH KPI Dashboard*** (**Figure 77.A**). The ***SDOH KPI Dashboard*** aggregates SDOH data from claims and assessments to analyze member patterns and trends in barriers to care. The Dashboard shows SDOH screenings completed by month and members with SDOH needs by category (employment, housing, education). The Dashboard can assess the cost and utilization metrics by SDOH need category and by population segments such as age, race/ethnicity, and gender.

Overutilization. We promote the right care, right time, and right place philosophy for our members and providers. We post information about the American Board of Internal Medicine Foundation's ***Choosing Wisely*** initiative on our provider website. This program discourages overutilization of inappropriate services by providing evidence-based recommendations for providers and their patients to discuss, such as when tests and procedures may be appropriate.

Nebraska Total Care identifies overutilization using claim and encounter data; information from prospective, concurrent, and retrospective reviews and drug utilization reviews; analysis of adverse determinations; and Care Management information. We monitor and analyze data at the aggregate and detail levels by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and region; and compare services authorized to services received. Each analysis drills down to more specific areas of interest. When reviewing ED visits or inpatient utilization, we review the total number of visits or days, and the utilization in relationship to readmissions, frequent ED utilization, and presence/absence of provider office visits.

We identify members for engagement and support using our Member High Utilization Reports. These reports integrate PH, BH, dental, and pharmacy claims/authorizations; evidence-based SDOH mini-screen; Care Management Priority Report; and real-time ADT data to identify members who may have higher utilization of services due to BH and/or complex medical needs (wound care, respiratory care, or chronic conditions) or whose barriers to preventive services result in a reliance on EDs or crisis services. We prioritize members at or above pre-determined risk thresholds for immediate outreach, education, Care Coordination, and interventions.

Reducing High ED Use

Our highly effective ED Diversion program **reduced ED use by 27.2%** between 2017 and 2021. Our ED Diversion program proactively identifies members with frequent ED use for education and intensive Care Coordination to help address barriers to care, including SDOH (for example, healthy foods, stable housing, health literacy).

"Nebraska Total Care is a godsend for my patients. You are amazing to work with, regardless of whether it is an inpatient authorization or removing barriers to care. When Nebraska Total Care removed prior authorization for IM Vivitrol, it was a godsend for my patients with opioid addiction. I've noticed that patients who receive long acting medications have a much easier time with relapse prevention, and I'm not seeing the readmissions related to medication noncompliance."

- Dr. Sattar, Medical Director, Inroads to Recovery

Developing and Reviewing Utilization Review Criteria

Nebraska Total Care uses evidence-based utilization review criteria relevant to the Heritage Health population to ensure effective care in the most appropriate setting. Through the UMC, appropriate practitioners participate in developing, adopting, and reviewing criteria. We use utilization review criteria as an objective screening guide; they are not intended to be a substitute for physician judgment. We make utilization review decisions following currently accepted medical or health care practices while taking into consideration both the unique member needs or complications and the available local delivery system.

Utilization Review Criteria. Nebraska Total Care adopts criteria from nationally recognized organizations that establish standards for clinical decision management; MLTC's definition of medical necessity; and internally developed clinical policies and guidelines (in the absence of nationally recognized review criteria or where local practice patterns do not align with InterQual). We apply the following criteria in **Table 77.B** to determine medical necessity and appropriateness of care for prior authorization, concurrent inpatient review, and retrospective review.

Table 77.B Our qualified UM staff apply standardized guidelines and criteria to determine medical necessity.

Standardized Guidelines and Criteria	Requested Services
Federal and State Regulations	All services as applicable
MLTC Contract and Medicaid Manuals	All services as applicable
InterQual Connect™ Level of Care and Care Planning Criteria	Pediatric acute, adult acute, home care, durable medical equipment, and procedures
Subacute/Skilled Nursing Facility Guidelines	Subacute or skilled nursing care for members with catastrophic conditions or special health care needs
InterQual *Connect™* Guidelines	BH inpatient, psychiatric residential, partial hospitalization, intensive outpatient, and outpatient therapy services
ASAM Criteria	Inpatient and outpatient substance use disorder services
Internally Developed Guidelines	All services as applicable

Dental Criteria. We will delegate medical necessity determinations for authorization requests for dental services to Envolve. Envolve applies clinical criteria and authorization processes to manage service utilization requests according to medical necessity and appropriateness of care. Clinical criteria are developed by specialists and defined by the American Academy of Pediatric Dentistry; American Dental Association; Centers for Medicare and Medicaid Services; specialty journals and/or periodicals; information presented at dental seminars; and other clinical guidelines as defined and/or approved by Envolve's UM Committee with local dental provider input. Envolve Medical Directors review and revising clinical criteria annually. The Envolve Quality Improvement Committee approves the revised criteria annually. Envolve lists the required documentation to support authorization requests per code in the benefit grids available to providers on the Envolve Provider Web Portal and website. We will monitor Envolve's compliance with their service level agreement through data provided in the monthly dashboard and results of internal UM program monitoring.

Internally Developed Guidelines. Nebraska Total Care uses internally developed guidelines to wrap around InterQual. Our parent company's national Clinical Policy Committee (CPC), which includes Medical Directors and nurses from affiliate health plans, develops criteria in the form of Clinical Policies. The CPC reviews sources including scientific literature, government agencies such as Centers for Medicare and Medicaid Services (Coverage Determinations and other policies), specialty associations, and input from relevant specialists with expertise in the technology or procedure. Nebraska Total Care's CMO submits guideline development requests to the CPC. The CPC develops guidelines based on such requests and new technologies, procedures, and certain durable medical equipment identified during its quarterly reviews. Our CMO works with the CPC and MLTC to ensure guidelines address Nebraska requirements and the needs of Heritage Health members. Nebraska Total Care uses Hayes Technology Assessments to evaluate new technologies. Hayes rates technologies to reflect the strength and direction of the evidence regarding a medical technology (procedure, test, device, biologic, drug, intervention, process, or program). This includes safety and efficacy, impact on health outcomes and patient management, indications for use, and patient selection criteria compared with the standard treatment/testing or other competing health technology. We develop or revise guidelines due to new technology or procedure, a new use for existing technology, or a negative trend in the length of stay or utilization. The CPC reviews clinical policies annually, or more frequently as needed.

Data and Processes to Determine Which Services Require PA

We believe in focusing PA on procedures and services where we see wide variations in practice. Should our analysis indicate that most authorizations for a specific service are approved, we would recommend removing the PA requirement. For example, we identified that 99% of authorization requests for observation stays up to 48 hours were approved. After our data-driven analysis of the probability of approval and impact on quality and appropriateness of care, we removed the PA requirement to reduce provider administrative burden and streamline members' access.

Nebraska Total Care routinely reviews utilization data to determine which services will require PA. MLTC provider bulletins or other updates trigger a review of indicated services. We review and update annually, or as necessary, our list of services and codes requiring PA. We update our PA list to add or remove PA requirements based on approval and appeal rates, cost data, and risk for misuse. We present UM reports on PA trends to the Population Health Management and Clinical Operations Committee and Quality Improvement Committee at least quarterly.

Quarterly, our parent company publishes updated codes with recommendations regarding the addition or deletion of services requiring PA. Nebraska Total Care and other affiliate plans review these recommendations relative to their contracts, regulatory environments, utilization experience, past UM review outcomes, and the local health care landscape to determine whether to accept or decline the recommendations.

Reevaluation of Services Requiring PA

The annual review of services and codes requiring PA evaluates utilization patterns, denial rates for specific PA types, provider complaints/appeals, member satisfaction, and issues identified via IRR testing to determine:

- If a PA requirement should be implemented to manage overutilization or inappropriate utilization
- If the PA adverse determination rate is so low as to deem it unnecessary
- If a PA requirement needs to be revised to improve clarity and consistency of application
- Other changes to streamline the process while ensuring quality and appropriateness of care approved

We will remove PA requirements when we determine review does not favorably influence the quality of care.

"Madonna Rehabilitation Hospital admits very complex patients. In several instances, we have had to contact Nebraska Total Care to work with us on outlier situations. This health plan has always been willing to work with us and help us resolve discharge barriers with their members. They have also been willing to work with our therapy staff when the goal is to get the most appropriate equipment for our patients upon discharge and yet meeting the guidelines of the health plan/Medicaid. Their Medical Directors past and present have always been available to talk through difficult situations as such well. Nebraska Total Care presents itself as a caring Manage Care Organization and good steward to its members."

– Sharon Votava Director of Payer Relations, Madonna Rehabilitation Hospital

PA Processes for Non-Participating, Out-of-Network Providers

Nebraska Total Care never requires PA for emergent or urgent care, including BH crisis services, or those services specifically exempt from PA by contract, such as family planning. In an emergency, whether in or out-of-network (OON) or area, we advise members to immediately dial 911 or help them find the nearest urgent care center. Our systems pay for emergent or urgent services for both in and OON providers without authorization.

If a member requires non-urgent or non-emergent services unavailable from a qualified network provider, Nebraska Total Care adequately and timely covers the services through an OON provider. Using our PA process, a decision to authorize the use of an OON provider is based on continuity of care, availability or location of an in-network provider of the same specialty and expertise, and complexity of the case. Outside of the determination of OON need, ***OON providers and services fall under our standard PA protocols and timelines***. Always striving to match provider experience and qualifications to the clinical acuity, specialization requirements, linguistic capabilities, cultural competence, and/or scheduling needs of our members, we would never deny a PA solely for being OON.

OON PA Process. PA requests for OON services are submitted to UM, before going to the SCA unit. Upon receipt, the UM designee completes a Level One review based on written policy to ensure medical necessity and that OON criteria are met, such as continuity of care, difficult-to-find service(s), or unavailability of an in-network Provider within time and distance standards. All OON requests are submitted to the Medical Director for final determination (either approved or denied), including the following:

- Reason for requesting an OON Provider
- Results of the in-network search
- Medical necessity review, if required
- Name and specialty of the OON Provider
- Attempts to steer back in-network
- Any additional information to demonstrate a need

Upon determining the service is medically necessary and there is no appropriate in-network option, UM staff completes an SCA Needed – Initial Request Form and sets an SCA Needed Task to the contracting group queue within our clinical documentation system for SCA follow-up. Our SCA unit negotiates SCAs for all non-contracted in and out-of-state providers.

SCA Requirements. The first step in our SCA process is the validation of Medicaid enrollment and medical license status, and provider review against all exclusion lists. Once validated, we offer eligible providers both an SCA and a full network agreement. If an OON provider is willing to accept standard Medicaid FFS rates, an SCA is not required. SCA staff document provider fee acceptance in the existing PA which ensures appropriate claims processing. If an OON provider is unwilling to accept standard Medicaid FFS rates, SCA staff look for an alternative OON provider, and if not available, initiate negotiations with the approved OON provider. Upon approval of rates, we create, sign, and document an SCA to ensure appropriate notification and payment. Our SCA Team meets weekly to review and approve SCAs; we have an expedited process to review time-sensitive requests. We offer providers a network agreement and execute an SCA at the same time to ensure timely access.

SCA Documentation. The SCA or PA captures necessary information about a provider's credentials, including name, address, tax ID, and NPI, which allows us to load the provider in the system to process the claim. The SCA unit uses a statewide database to identify and document all OON providers delivering services to members. The Network team has continued access to this database to support provider outreach, network development, and follow-up to extend contracts to these providers as appropriate.

Expedited PA Process

If a provider indicates, or Nebraska Total Care determines, that we must expedite the timeframe for making a determination due to the nature of the member's condition, we make an expedited authorization decision and notify the

requesting provider as expeditiously as the member's health requires, and ***no later than 72 hours of receiving the request for service*** per SOW N.17.b. If the member requests additional time to submit clinical information, or we can justify that it is in the member's best interest, we can extend the timeframe up to 14 calendar days per SOW N.17.c., making the determination expeditiously once the additional information is received, and no later than the expiration of the extension.

Nebraska Total Care's 24/7 Nurse Advice Line has access to on-call UM nurses and Medical Directors to ensure timely authorization of expedited requests after hours. To ensure timely processing, ***Nebraska Total Care assigns specific UM Clinical Reviewers to review expedited requests***. A clinical reviewer (nurse or BH clinician) reviews the request against our adopted utilization review criteria. If the request does not meet the criteria, it is referred to a Medical Director or other practitioner for second-level review. Only the Medical Director/appropriate practitioner makes adverse determinations. If the determination results in a denial, reduction, or termination, we notify the requesting provider orally (and member in the case of an adverse determination) immediately upon making a decision. We follow up with written notification within one business day of the decision, not to exceed the 72-hour timeframe for determination, unless an extension is granted. The notice includes the reason, the right to a peer-to-peer discussion, the right to an appeal, and the appeal process.

Nebraska Total Care Consistently Meets Expedited PA Timelines

In 2021, Nebraska Total Care met the 72-hour turnaround time for **99.65%** of expedited PA requests for PH, and **100%** for BH services.

78. Describe the Bidder's approach to utilization management: including:
• How the Bidder will use its UM Committee to support UM activities
• The role of the Clinical Advisory Committee in developing service authorization procedures.
Page Limit: 2

Nebraska Total Care's approach to utilization management (UM) includes appropriate program oversight by leadership, measurement of effectiveness, and engagement of the stakeholder community. This ensures UM meets the goal of optimizing members' health status, their sense of wellbeing, productivity, and equitable access to quality health care, while actively managing cost trends. UM provides integrated Behavioral Health (BH), Physical Health (PH), and pharmacy services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. Dental UM services will be incorporated into our existing proven processes with the expanded scope of work, leveraging the experience of our affiliate, Envolve Dental, Inc. (Envolve), currently in use by 13 of our affiliate plans. The Utilization Management Committee (UMC) provides oversight, and the Clinical Advisory Committee (CAC) obtains comprehensive stakeholder input and feedback.

How Nebraska Total Care Uses its UMC to Support UM Activities

The Nebraska Total Care Board of Directors oversees the development, implementation, and evaluation of the UM program and approves the annual UM program description, annual evaluation, and work plan. The Board delegates daily oversight and operating authority of UM activities to the UMC, which reports to our Quality Assessment and Performance Improvement Committee (QAPIC). The UMC is responsible for the review and appropriate approval of medical necessity criteria, protocols, guidelines, grievances and appeals, including expedited appeals and State Fair Hearings related to UM activities to determine any needed policy changes, and UM policies and procedures related to BH, PH, and pharmacy services. The UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, appropriate use of services and resources, and member and practitioner satisfaction with the UM process. Envolve has a dedicated Dental UMC that reports to the QAPIC.

Dr. Chris Elliott, Nebraska Total Care's Medical Director, oversees our UM program and provides leadership for the continuous improvement of our UM processes. Dr. Elliott is a physician currently licensed (without restrictions) to practice medicine in Nebraska. He is board-certified in family medicine with extensive experience in BH and PH working in family practice and ED settings. He has nearly four years of experience serving in a Medical Director role. Nebraska Total Care's BH Medical Director, Dr. Wendy Welch, is a practicing psychiatrist with an unrestricted license and 20 years of experience across psychiatry, BH, addiction, and PH care environments. She is triple boarded by the American Board of Psychiatry and Neurology in Psychiatry, Child and Adolescent Psychiatry, and Addiction Psychiatry. Dr. Welch is involved in implementing, monitoring, and directing the BH care aspects of the plan's UM program and participates in UM and integrated care team rounds to assist in identifying BH care needs and integrating BH and PH care.

UM for Dental Services. In partnership with the Nebraska Total Care Dental Director, Envolve will be accountable for all dental UM oversight activities required in the SOW, including monthly reports and calls. Envolve holds NCQA accreditation for UM and has the experience and proven processes in oversight of all dental UM activities, including established UM/QI programs since 2014. Envolve leverages the support from dental partnerships such as the UNC School of Dentistry and a panel of dental consultants to develop and maintain clinical policies in line with ADA guidelines. Envolve has increased member access to dental care through innovations such as launching a dental health van for dental education and screenings; working with health plans to provide dental services in schools; ensuring FQHCs are in-network and physical and dental care is coordinated; paying for teledentistry services to the full extent of State law.

Established Policies and Procedures. UM policies and procedures describe the process by which we conduct prospective, concurrent, and retrospective reviews for medical necessity, referral management, second opinions, and coordination of care with other clinical functions. The UM program description, which is sent to MLTC annually for review and approval includes this information as well as the plan's approach to evaluating the quality of care provided to members with special health care needs (SHCNs).

Meeting the Needs of Members with SHCN

Members with chronic illnesses often have two or more conditions (58.64% of adults and 18.51% of children). When determining medical necessity, we consider this, along with potential health disparities and Social Determinants of Health (SDOH).

Monitoring UM Data. All UM data is reported to the UMC quarterly unless we identify significant variances or outliers requiring immediate intervention. In such cases, the Medical Director and the Vice President of Population Health and Clinical Operations assess the variance and recommend appropriate action. Routine reports provide a comprehensive

analysis of data, including identification of variance or trends, review of outcomes, and recommended interventions based on the findings. The UMC makes recommendations that may include additional data analysis, continued monitoring of a process or provider, and/or corrective action. Recommended actions may be multi-departmental; revisions to prior authorization requirements; new or revised clinical practice guidelines or criteria; network development activities; improvements in UM data collection and monitoring; staff and/or provider training; or addressing the practice patterns of a particular provider or the utilization patterns of an individual member.

Example of Process Improvement Generated from UMC Oversight. In 2021, we identified high rates (99%) of approval for observation stays across condition types. After investigation using data analytics, member outcomes, feedback from providers, and in consult with MLTC, we changed the policy and notified providers that observation stays of less than 48 hours would no longer require authorization. This reduced the administrative burden for providers without an increase in cost.

How Nebraska Total Care Uses its Clinical Advisory Committee (CAC) to Support UM Activities

Nebraska Total Care's CAC, along with our ***Provider Advisory Committee (PAC), Tribal Advisory Committee (TAC), and Member Advisory Committee (MAC)*** provide regular input and feedback from the stakeholder community, including PH and BH providers, Federally Qualified Health Centers, rural health clinics, and community-based organizations. By go-live, we will incorporate dental providers and dental hygienists into our CAC, PAC, and other quality committees who will help us achieve an appropriate focus on preventive dental services.

Our advisory committees supply providers, members, and other stakeholders' with feedback regarding health plan operations from multiple disciplines and perspectives. The purpose of the CAC is to inform UM processes and procedures and facilitate regular consultation with practitioners on standards of practice and treatment for members receiving medical, behavioral, pharmacy, or dental health services. Collectively, in conjunction with our Health Equity and Diversity Committee (HEDC), these committees help us improve health outcomes for members of all racial, ethnic, cultural, geographical, economic, linguistic, and religious populations including those with disabilities and across various diagnoses by evaluating data on potential disparities and suggesting interventions to improve health equity. The CAC's goal is to solicit input into policies, procedures, and practices associated with Care Management and UM functions. The CAC develops clinical and practice guidelines and UM criteria that reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska. The committee reviews and approves the clinical practice guidelines recommended by Centene's Clinical Policy Committee before adoption by Nebraska Total Care. The committee includes five representatives serving children, adolescents, and adults across the State in both rural and urban areas, representing a variety of races and ethnicities reflective of the population. The committee includes pharmacists, medical providers, public health, BH, and dental providers.

Examples of Improvement Generated from CAC. In 2021, a CAC participant identified that providers lack knowledge around how to communicate and appropriately address the needs of LGBTQAI+ patients with appropriate sensitivity to inclusiveness. Nebraska Total Care created training to educate providers on unconscious bias and inclusiveness as it pertains to members of the LGBTQAI+ population as well as other cultural diversity. ***In the first quarter of 2022, 89 participants completed our Cultural Competence – Moving from Cultural Competence to Cultural Humility course which includes considerations of the LGBTQAI+ population. Participants' understanding of cultural competence improved by 13%.*** This improved awareness helps providers communicate with members to achieve optimal engagement and improve outcomes. Cultural competence is included in ongoing provider orientation sessions.

In another example, the CAC discussed ways to improve aftercare for children in foster care who experience hospitalization for BH conditions. The committee identified that additional information, such as location and city would be beneficial for analyzing the data and making recommendations. As a result, we are finalizing a foster care health equity dashboard to support data drill down to identify interventions to support post-hospital needs. To further support these efforts, we are developing a Community Partner Portal, similar to the provider and Member Portals, which will allow external Case Managers direct access to member information for coordination of care.

79. Describe the process the Bidder will have in place to establish appropriate clinical practice guidelines including physical health, behavioral health, and dental, notify providers of new practice guidelines, and monitor implementation of these guidelines. ***Page Limit: 2***

Process to Determine Appropriate Clinical Practice Guidelines

Nebraska Total Care's commitment to clinical quality has many facets, including providing a basis for consistent decisions for utilization management (UM), member education, service coverage, and provider treatment. We base our guidelines on MLTC rules for medical necessity, valid and reliable clinical evidence, a consensus of health care professionals practicing in the relevant field, and the needs of members. This includes children with serious emotional disorders and adults with serious and persistent intellectual/developmental disability (I/DD). We adopt and publish new and updated clinical practice guidelines (CPG) developed by the most reputable medical and psychiatric organizations, including the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, The American College of Obstetrics and Gynecology, and the American Psychiatric Association. Using these national resources, CPGs are posted on the website for practitioners' review and feedback and are presented to our Clinical Advisory Committee (CAC). We participate in Centene's Clinical Policy Committee (CPC) to review updated guidelines. We apply any needed updates or changes to the guidelines before we submit them to the providers and members of our Quality Assessment and Performance Improvement Committee (QAPIC) for review, suggestions, and approval.

Nebraska Total Care has implemented CPGs that are valid and reliable, evidence-based, consistent with national standards, and per 42 CFR 438.236. We will continue to obtain prior approval from MLTC for new or updated practice guidelines and UM guidelines. All care decisions related to medical necessity determination, course of treatment decisions, and member education are consistent with the established CPGs.

Our dental benefits manager, Envolve Dental, Inc. (Envolve) uses clinical policies developed from evidence-based practice guidelines published by the American Dental Association. These policies will be reviewed and approved by Envolve's dental UM committee made up of Envolve's executive leadership, our Chief Medical Officer, Dental Director, designated UM and quality staff, operational staff such as networking/contracting, member and provider services, compliance, and network practitioners representing the range of services within the network and across the service area. Dental CPGs will be submitted to our CAC and Dental QAPIC.

CPG Process Example. In June 2020, in developing provider education and messaging related to the HEDIS Measure ADD, which focuses on follow-up care for children prescribed ADHD medications, we discovered the guidelines of HEDIS Measure ADD were not present in the approved ADHD CPG. Therefore, we submitted the ADHD Clinical Practice Guideline from the Academy of Pediatrics for review to the CPC in June 2020, and it was approved. We submitted the amended Preventive Health and Clinical Practice guidelines to CAC in July 2020, subsequently approved by QAPIC, and posted on our website.

Current and Proposed Clinical Practice Guidelines and Preventive Health Guidelines

Nebraska Total Care has adopted and disseminated 36 physical health and 12 behavioral health (BH) CPGs and preventive health guidelines (PHG) reflecting the best preventive and wellness practices (trauma-informed care, pediatric preventive care, pediatric and adult immunizations, lead screenings, weight management), and exemplary management of common acute and chronic conditions (asthma, diabetes, back pain, sickle cell, heart failure). These include BH and substance use disorders (SUDs) (addressing suicidal behavior, major depressive disorder, bipolar disorder, attention-deficit/hyperactivity disorder, and use of psychotropic medications). We post our current guidelines on our website. Nebraska Total Care looks forward to the opportunity to collaborate with other MCOs to achieve administrative simplification for providers including streamlining requirements by aligning CPGs and PHGs across MCOs. We can accomplish this through discussions with the MCO association or via less formal means, as we demonstrated through our leadership of the MCO effort to standardize BH definitions.

Envolve has adopted 44 clinical policies for the prevention, care, and treatment of dental conditions using evidence-based practices and the recommendations of the American Dental Association. Envolve will present these guidelines for review, feedback, and approval by the CAC (which will have dental provider representation) and the Dental QAPIC before adoption by Nebraska Total Care and submission to MLTC.

Notification to Providers of New Practice Guidelines

We encourage providers to consistently utilize practice guidelines that reflect the highest standards of preventive, curative, and rehabilitative care. We communicate this expectation in contracts; our training, newsletters, and updates; and in Value-Based Purchasing (VBP) arrangements, through which we provide technical assistance and reward providers for achieving quality metrics. Our CAC plays an important role in adopting guidelines, disseminating evidence-based practices, and emphasizing the importance of adherence. We distribute CPGs to all practitioners via our Provider Portal and the Envolve Provider Portal (for dental) and upon request to members in a printed format. All current and potential members and

providers have access to the CPGs on our website. Our Provider Handbook includes references to all adopted CPGs and PHGs and links to the full guidelines are available on Nebraska Total Care's and Envolve's websites. Directions are provided for requesting a hard copy and how to participate in CAC or provide feedback on CPGs. Mechanisms to notify and distribute guidelines include:

- New provider orientation materials
- Member Handbook
- Fax blasts with updates
- Provider and Member Newsletters
- Special mailings, for example, CPGs and PHGs are summarized in the QAPIC Annual Program Evaluation

Facilitating Compliance with CPGs. By involving providers in the selection and adoption of CPGs, distributing performance data, and offering technical assistance, Nebraska Total Care obtains valuable input on guideline structure and improvement activities to maximize acceptance by the provider community. We use Centelligence, our reporting and analytics platform, to monitor indicators that measure guideline performance, and we include this data and comparative benchmarks in our provider profile reports. Our Provider Portal offers access to practice-level clinical quality reports so providers can self-monitor CPG compliance. The Provider Portal displays member-level care gaps (with practice-level summaries) that identify panel members in need of specific guideline-recommended preventive care and chronic condition-related services. Our Care Management and Disease Management programs are consistent with and support compliance with approved CPGs. The staff educates and guides providers on CPGs when they are serving members who have relevant conditions.

Monitoring Adherence to Guidelines. Every quarter, our Quality team randomly audits five patient records for providers with a panel of 50-1,000 members, and 10 records for those with over 1,000 members, to evaluate the utilization of select guidelines (different each quarter) that are aligned with HEDIS measures. We analyze adherence metrics in conjunction with other data, such as complaints, adverse incidents, and results of focused quality reviews. We use provider HEDIS rates to substantiate provider compliance with CPGs. If the performance rates fall short of established goals, we implement targeted interventions for improvement. For example, if an individual provider is non-adherent to guidelines, we provide focused education and technical support. When we identify a trend that seems to be impacting multiple providers, we investigate barriers and implement improvement interventions which may include education, policy or process changes, and support tools. In a recent Performance Improvement Project, we assessed members not receiving a Tdap (tetanus, diphtheria, and pertussis) vaccine in pregnancy. We profiled the practitioners who provided their care protocol, and we sent a letter with information to guide them on best practices. For providers who have continued difficulties meeting practice guideline-based performance standards as evidenced by member record audits and provider data reviews, as well as patient complaints, grievances, and appeals– we develop Corrective Action Plans beginning with clinical education and escalating to credentialing actions when necessary. This is a cooperative effort. Together, we work toward providing the highest quality care for members.

Providers Demonstrate Increased Compliance to Guidelines

From 2019 to 2021 providers under VBP contracts showed the following HEDIS measure improvements:

- 31.1% increase in combo 10 childhood immunizations
- 13.2% increase in controlling high blood pressure
- 10.4% increase on adolescent immunizations
- 2% increase in breast cancer screening
- 15.4% increase in lead screening
- 12.8% increase in well-child visits in the first 15 months of life

Monitoring Internal Adherence to CPGs. To ensure consistent application with Nebraska Total Care policies and procedures, we review UM criteria, member education materials, benefits information, and other documents against CPGs. We conduct an annual assessment to review CPGs and ensure that decisions are made consistently. At least annually, we assess all PH and BH UM staff responsible for decisions regarding UM and coverage of services (licensed clinical staff and physicians) to ensure consistency in decisions with the CPGs/PHGs (to include dental in the future). We require an overall assessment score >90% for each staff person. Staff who do not score at least 90% are remediated and retested. The CPG components are built into TruCare Cloud, our collaborative Service Coordination and UM platform, which allows Care Management and Disease Management program staff to track compliance.

80. Provide specific initiatives the Bidder will implement to limit waste in the existing system and to improve cost efficiency. Provide specific information regarding the initiatives that will be pursued to improve cost containment and enhance quality including the stakeholders involved, the timelines, and the desired outcomes. ***Page Limit: 4***

Working with Nebraska Total Care, MLTC experiences limited waste in the system as well as cost efficiencies resulting from our multi-prong strategy to provide our members with consistent, ***high-value care*** that adheres to ***evidence-based*** clinical practice guidelines. We have in place established and comprehensive payment policies, pre-payment edits, and post-payment review processes aligned with MLTC payment policies, covered services, Federal and State regulations, and national coding best practices. These payment integrity interventions form the bookends to our utilization management (UM), Care Coordination, quality management, and provider network processes, ensuring member access to the ***right care, at the right time, and in the right place.***

Data-Driven PA Elimination

Data monitoring in 2020-2021 revealed 99% approval rate for observation stays in the first 48 hours. As a result, we eliminated PA requirements for under 48-hour services to relieve administrative burden on providers.

As a data-driven organization with a focus on continuous quality improvement, we leverage the Centelligence reporting and analytics platform for data collection, performance measurement, analysis, and predictive modeling. We use a formal process for investigating potential causes, developing and implementing interventions, and evaluating and monitoring results, making necessary improvements along the way including identifying and addressing potential health disparities. We bring key performance metrics to the appropriate subcommittee, and ultimately to the QAPI Committee. For example, the UM Committee reviews trends in cost and utilization, along with authorization rates, and may recommend adding or eliminating prior authorization (PA) requirements.

Initiatives to Limit Waste and Improve Cost Efficiency

Cost of Care Workgroup

Stakeholders Involved	Timeline	Desired Outcomes
Enterprise Cost of Care Workgroup	Ongoing	Development of initiatives that reduce the overall cost of care based on identified trends

We host a multidisciplinary Cost of Care workgroup supported by Centene's Corporate Analytics division that meets monthly to monitor and review cost of care and utilization trends. We investigate trends that are favorable or unfavorable to the cost or quality of health care, with further analytics and careful consideration of cost and utilization drivers. For example, in April of 2022, the Cost of Care workgroup identified an increase in the cost of ambulance services in Nebraska, increasing from $1.95 PMPM in 2019 to $2.03 in 2020, and $2.45 in 2021, without a parallel increase in ED use. Upon deeper investigation, the group identified that 82% of the PMPM cost was for emergent transportation to a hospital and 18% was for non-urgent trips. This raised the discussion of how to encourage more economical non-urgent transportation such as SafeRide, instead of ambulance services. This group looked at frequent ambulance users for trends and opportunities for intervention. The top three users had 50, 32, and 31 rides, respectively, within 12 months. The most common reasons were alcohol intoxication, altered mental status, and pain. All frequent users were referred to and engaged with Care Management, and PCPs were engaged to help manage the excess utilization. All departments have a list of conditions that require referral to Care Management, which now includes the use of ED or ambulance services for non-urgent conditions. Care Managers work with members to stabilize their condition, address SDOH, educate the member on non-emergency transportation and health care options, and work with the member's care team on ways to improve outcomes.

Utilization Management Program

Stakeholders Involved	Timeline	Desired Outcomes
Our UM/Care Management programs receive input from members, PCPs, and specialty providers via CAC, Provider Advisory, and Member Advisory committees	Ongoing since the inception of the contract	Rates of inpatient visits decreased YOY 2018 through 2021, a 35.7% drop; ALOS decreased by 4.1%

Our UM program is built on evidence-based clinical practice guidelines, thoroughly vetted clinical policy and national best practices. By performing PA of medical, behavioral, and dental services, as well as medications and procedures, we ensure that all member care is medically necessary and appropriate for the specific condition and circumstances of the member. Concurrent review of inpatient, rehab and skilled nursing stays, along with proactive discharge planning and follow-up for

members with complex conditions ensures that members receive the most appropriate level of care and transition safely home or to a community setting with appropriate services in place upon discharge.

Emergency Department (ED) Diversion Program

Stakeholders Involved	Timeline	Desired Outcomes
Care Management, Provider Contracting, PCPs and specialists, hospital representatives, and VBP partners work together to reduce ED use	Implemented in 2018	ED visits decreased by 27% from 2017-2021

We proactively identify members with overutilization of the ED through our ED diversion program. We use member education and intensive Care Coordination to help members address barriers to care including SDOH (for example, healthy foods, stable housing, and health literacy). Our ED diversion program includes the following activities:

- Our Centelligence reporting and analytics platform includes predictive modeling solutions incorporating evidence-based, care gap/health risk identification applications that identify and report significant health risks at the population, member, and provider levels, including predicting excessive ED use.
- Care Management receives a daily ADT report utilizing CyncHealth data and an ED super-utilizer report that identifies members with frequent ED visits. Care Managers use these resources to engage members in care.
- Care Management makes outreach calls to members who called the Nurse Advice Line (NAL)
- Our Community Health Workers (CHWs), located across the State, provide local support to members by making home visits and engaging them in the community. We train CHWs to educate members on appropriate ED utilization and alternatives to the ED. We assign CHWs to support Nebraska's Tribal communities.
- Care Managers assist members in obtaining follow-up care, educate them regarding the appropriate use of the ED, and underscore the importance of primary and preventive care. They help members understand how and when to use the 24/7 NAL and the closest urgent care facilities. They address barriers to care, assess health literacy and self-management, and coordinate care among providers. This includes working with dental providers to manage dental pain, a common reason for ED visits.
- Care Managers work with Provider Contracting Representatives to identify members with high ED utilization and conduct Care Coordination meetings with the staff of our Value-Based Purchasing partners. Meetings leverage combined resources to develop action plans to improve member health outcomes and decrease disparities.
- Care Management and Provider Contracting convene member-specific multi-disciplinary care conferences on super-utilizer members as warranted. These conference calls include Care Management, UM, Provider Contracting, PCPs, specialists, and hospital representatives. Together they work to identify triggers/motivations for ED visits and problem-solve for interventions and solutions. This teamwork is highly successful in reducing ED utilization.

ED Diversion Program Reduces Overutilization

ED use declined 19% between 2019 and 2020. In 2021 potentially preventable ED use declined 3.7%, demonstrating more appropriate use of services.

"Since the inception of Heritage Health, Health Center Association of Nebraska (HCAN) and Nebraska Total Care have maintained a collaborative partnership focused on enhancing and expanding access to care for Nebraska's underserved populations. Whether it is working together to address administrative questions to supporting outreach efforts in Nebraska's Federally Qualified Health Centers (FQHCs), Nebraska Total Care has always maintained an open, cooperative relationship with us. Our current work on Project Access will profoundly change the ability of Nebraska's FQHCs to expand access to medical, dental, and behavioral health services; ensure the recruitment and retention of a mission-driven workforce; and stabilize access to care in rural and underserved communities across the state. Nebraska Total Care understands the unique needs of Nebraska and works closely with community partners to address barriers to accessing health care. We are grateful for our long-standing partnership and look forward to expanding our mutual work in the future."

- Amy R. Behnke, CEO, Health Center Association of Nebraska

Transition of Care (TOC) Program

Stakeholders Involved	Timeline	Desired Outcomes
Members, Care Management, PH and BH providers, facility discharge planners, community resources, and VBP partners; we are working with Brave Health, a virtual Community Mental Health Center, to support broad BH telehealth access that will accept Case Management and provide direct referrals to support members receiving 7- and 30-day appointment follow-ups	Implemented in 2019 and ongoing	An increase of 36% in BH-related PCP spends PMPM, while BH-related inpatient spend decreased by 26.3% (YOY decrease due to effective TOC and more appropriate BH condition management); BH-related ED spend decreased by 2.1%

A key component of our Care Coordination model is our evidence-based TOC program. Our holistic, member-centered TOC program facilitates access to needed health and recovery services, including social and community supports, to ensure safe transitions to the most integrated community setting possible. Our approach considers needs related to barriers and the member's social context, and we provide intensive support after discharge for those at high risk for readmission. The program emphasizes prevention, continuity of care, coordination, and integration of PH and BH incorporating evidence-based principles shown to reduce avoidable readmissions. Our TOC staff, in partnership with the UM and Care Management teams, begin to plan for discharge upon admission (or upon enrollment for members already in an institution at the time of enrollment), adhering to policies and procedures which address all transitional Care Management requirements across all settings and levels of care. We performed 4,209 TOC assessments in 2020, and 4,748 in 2021. Our TOC program provides transition of care activities including:

TOC Program Contributes to Decreased Inpatient Use

Inpatient admissions decreased year over year from 2018 to 2021 resulting in a cumulative 35.7% decrease in inpatient admissions and a 26.3% decrease in BH admissions.

- Assessment of the barriers which led to the member's admission or readmission
- Partnership with the member and facility discharge staff for transition planning that considers the PH, BH, and social needs of the member and coordination of appropriate care after discharge from one level of care to another
- Appropriate support in obtaining referrals, locating providers, scheduling follow-up appointments and transportation, DME, supplies, and medications; and accessing non-covered and community services to keep them safe
- Timely communication with the PCP about discharge plans and changes to the plan of care
- Post-discharge follow-up and monitoring to ensure services are in place and effectively maintain the member safely in the least restrictive setting

Start Smart for Your Baby and High-Risk Pregnancy Program

Stakeholders Involved	Timeline	Desired Outcomes
Stakeholders for Start Smart include OB/GYN providers, members, State and community-based organizations such as the WIC program, DHHS Healthy Mothers, and Healthy Babies Helpline; We partner with local agencies such as Public Health Departments and providers such as FQHCs to promote Start Smart	Implemented in 2017 and ongoing	From 2018 to 2021: 20.3% increase in pregnant members' risk-stratified; the average number of prenatal visits increased by 15.1% (Black members increased by 17.0% and Hispanic members increased by 13.4%)

Addressing Maternal and Child Health

Preterm deliveries, defined as a delivery before 37 weeks, and the resulting NICU admissions that follow these early births are a large portion of health care expenses across the United States. Centene developed the Start Smart for Your Baby® (Start Smart) program to reduce preterm deliveries and low birth weight babies and improve the health outcomes of both moms and babies. Start Smart includes enhanced member outreach and incentives, wellness materials, intensive one-on-one Care Management, provider incentives, and support for the appropriate use of medical resources to extend the gestational period and reduce the risk of pregnancy complications, premature delivery, and infant disease. An essential component of Start Smart is the Notification of Pregnancy (NOP) process. The NOP form aims to identify pregnant members at risk for pregnancy complications early in pregnancy and establish relationships between the member, provider, and health plan staff. Early identification of pregnant women and their risk factors through the NOP process and the monitoring of claims data is a crucial element in improving delivery and birth outcomes. Our ability to

monitor data specific to our Start Smart program, including provider-submitted NOPs and the use of maternal-fetal medicine (MFM) providers, allows us to stay on top of provider trends. We offer provider education related to the benefit of NOP submission early in pregnancy and the use of MFM providers for high-risk pregnant members.

Pharmacy Program

Stakeholders Involved	Timeline	Desired Outcomes
We contact providers for drug/drug interactions, de-prescribing/overuse, drug-age interaction, therapeutic duplication and adherence issues, gaps in care, and potential FWA	Implemented in 2017 and ongoing	In 2021, this initiative detected more than 5,000 prescription misuse

Nebraska Total Care's pharmacy program provides access to pharmaceutical services for eligible members and ensures these services are part of a covered benefit, medically necessary, appropriate for the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of pharmaceutical care. The Pharmacy program seeks to educate providers regarding the cost-effective usage of drugs, provide feedback about current prescribing patterns, and improve the quality of patient care. The program actively monitors utilization to guard against overutilization of services and fraud, waste, and abuse. Our pharmacy program includes a Drug Utilization Review, both prospective and retrospective, BH Medication Monitoring (to identify members who exceed targeted parameters for psychotropic medications), a Value-Add Wrap formulary (list of non-PDL covered drugs) approved by the Centene and Nebraska Total Care Pharmacy and Therapeutics Committees, and a Restricted Services Program (health and safety program) to address member overutilization of health care services by providing coordinated health care.

Improving "Nathan's" Quality of Life. Nathan had been prescribed over 46 medications for multiple complex conditions including PTSD, major depressive disorder, mood disorder, adrenocortical insufficiency with IVIG deficiency, migraines, chronic pain, and polyneuropathies. Nathan was unable to work and had difficulty engaging in his life. Nebraska Total Care staff facilitated a care conference which included Nathan, our Chief Medical Director, Director of Pharmacy, Director of Clinical Operations, Nathan's Care Manager, our Provider Partnerships Liaison, Nathan's providers, and Nathan's family. The team discussed Nathan's needs and coordinated his care. As a result, Nathan's IVIG injections were modified and the team reduced the amount of medications Nathan needed to 16, which helped Nathan feel better, experience fewer side effects, and improve his quality of life. Nathan continues to participate in monthly care conferences and his Care Manager follows-up with him every two weeks to ensure he continues to progress towards his goals.

Dental Program

Stakeholders Involved	Timeline	Desired Outcomes
Envolve's Peer Review Committee reviews inappropriate or unusual services including potential quality of care incidents, adverse events, and sentinel events	It will be implemented in 2023	Reduce waste in inappropriate or overuse of dental services

Our dental affiliate, Envolve, is focused on clinical, network, and operational processes that improve member health, eliminate waste and lower the per capita cost of dental care. Envolve has specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care policies. Required documentation to support authorization requests are listed per code in the benefit grids available to providers on the Envolve Provider Portal and website. Providers compare intended services to the clinical criteria before treatment begins to assure appropriateness of care. Envolve utilizes provider oversight to monitor performance levels and the appropriateness of services. This is measured through routine medical record review, potential quality of care review, grievance review, and member/provider surveys. This collective information is continuously tracked and analyzed to identify opportunities for improved cost containment and enhanced quality.

81. Describe the Bidder's process for:
• Notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.
• How the Bidder will ensure members receive written and timely notice of action relating to adverse actions taken by the Bidder.
Page Limit: 2

Timely Notice to Providers and Members

Both members and providers receive timely notification of Utilization Management (UM) outcome decisions, especially when the decision results in a denial, or when services are authorized in amount, duration, or scope less than what was requested. Our UM program ensures members have access to high-quality health care that is medically necessary and appropriate for their health and social situation, to promote optimal outcomes in the least restrictive setting. Denials or partial approvals may result from the recommendation of more appropriate service or setting, or because of inadequate information to determine medical necessity. In either case, we pursue prompt communication with providers and transparency with members. Members and providers may review the status of any request at any time by logging into the member and Provider Portals.

Timely Notice to Providers of Adverse Actions. When deciding to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested, we provide written and verbal notifications to providers, which comply with the timeframes outlined in the contract and meet the requirements of 42 CFR § 438.404.

We send Notification Letters to providers consistent with State and NCQA standards. They are easily understandable and include the member-specific rationale for the determination and specific criteria used. The letters tell the provider where they can access the criteria used to make the decision and the process and timeframes for submitting an appeal. We inform providers that peer-to-peer discussions with the Medical Director are available, and we include contact information. We fax approvals to providers within one to three business days and post them in the Provider Portal. Adverse determinations include verbal notification to the provider in one business day, followed by electronic notification.

UM staff monitor daily reports to ensure we process requests quickly and provide notice as expeditiously as the member's health condition requires and within State-established timeframes (not to exceed 14 calendar days following receipt of the service request). We only allow extensions to the processing time when a member or practitioner makes the request or Nebraska Total Care justifies a need for additional information and the extension is in the member's interest.

If the nature of the member's condition requires an accelerated determination, we make an expedited authorization decision and notify the requesting provider as expeditiously as the member's health requires, and ***within 72 hours of receiving the request for service*** per SOW N.17.b. If the member requests additional time to submit clinical information, or we can justify that it is in the best interest of the member, we can extend the timeframe up to 14 calendar days per SOW N.17.c.

As part of our appeal procedure, an informal reconsideration process allows the member or a provider, with written consent to act on behalf of the member, an opportunity to present evidence that may support overturning the denial or partial denial. The informal reconsideration occurs within one business day of the receipt of the request and is conducted between the provider rendering the service and the Medical Director or Dental Director authorized to make adverse determinations. We perform regular audits to identify opportunities for retraining and quality improvement.

Timely Notice to Members of Adverse Actions. Nebraska Total Care notifies members of decisions to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested (including providing member Notice of Adverse Benefit Determination on a denied clean claim which constitutes potential financial liability) to the member as required by the 2020 Final Rule published in the Federal Register, 11/13/2020, issue 24758. Typically, Medicaid members do not bear financial liability for services unless the service is denied or non-covered by the MLTC benefit plan. We only reimburse medically necessary services. Providers are not allowed to balance bill for covered services if the provider's usual and customary charge for covered services is greater than our fee schedule. Providers may bill members for services not covered by either Medicaid or Nebraska Total Care or for applicable copayments, deductibles, or coinsurance as defined by the State of Nebraska. For a provider to bill a member for services not covered under the program, or if the service limitations have been exceeded, the provider must obtain a Member Acknowledgement Statement. In these cases, members sign an acknowledgment of financial liability. We send a notice to the member when a clean claim or service has been denied exposing members to financial liability for the services rendered by a provider. We do not notify members when a denial is based on a technical error that providers and Nebraska Total Care can resolve directly with the provider, without member participation.

We only notify the member upon the initial denial of a service/clean claim, as subsequent notices may cause confusion and anxiety for the member. We notify members of the outcome of appeals. We send a Notice of Adverse Benefits Determination when there is:

- Denial of authorization for requested services including determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit, or denial of residential service requests
- Reduction, suspension, or termination of a previously authorized service
- Failure of the provider to render services promptly, as defined by the State
- Failure of someone or a company to act within the timeframes provided in the contract or within the standard timeframe for resolution of grievances and appeals
- Denial of a covered member's request to dispute financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other covered person financial liabilities

Member Notice Standards. Health literacy and the ability to obtain, process, and understand health information is a key driver in eliminating health disparities, creating equitable access to care, and improving health outcomes. We write member letters with consideration of members' health literacy and cultural sensitivity. We write notices at a sixth-grade reading level, in plain language (in English and Spanish), and they include a notice in 15 languages about where members can receive assistance. Staff support members when they have limited English proficiency or a disability. The notices include whether the service is partially approved or denied, the dates and amount of service, the date of the decision, the ability to request a copy of the criteria used, the process for an appeal if the member disagrees with the decision, ombudsman contact information, an authorized representative designation form, and a language assistance form. Approval letters include the authorization number. The notice of action to members is consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d). We monitor return mail to ensure members receive the notices we provide. If mail is returned undeliverable we reach out to the member and if needed, their providers, to obtain updated address information. We share updated addresses with the State.

82. Provide a listing of services for which the Bidder will require prior authorization and describe how the Bidder will communicate this information.

Page Limit: 2 Excluding the listing of services

Prior Authorization

Nebraska Total Care has a track record of decreasing the provider administrative burden associated with prior authorization (PA) as demonstrated by limiting PA requirements to only those procedures and services for which the quality of care can be favorably influenced by medical necessity or appropriateness of care review, and through the use of tools and technology to improve process efficiency.

For example, Nebraska Total Care offers an integrated family of secure, web-based tools to support ease of provider use, clinical quality, and operational efficiency, leveraging technology to simplify the utilization management (UM) process for providers and ensure a seamless system of care. Providers can look up whether a PA is required through a tool called ***PreAuth Check*** on our website. If needed, providers can submit requests for PA and inpatient authorization by phone, fax, or through our secure web-based Provider Portal. ***InterQual Connect™*** incorporates InterQual criteria through a fully automated, interactive workflow that supports real-time medical appropriateness review and determination for key services. This interactive workflow uses auto-determination rules to quickly approve or pend PA, providing a timely response to providers via our secure Provider Portal, and reducing overall turnaround time. We use our ***Authorization Digital Assistant,*** a machine learning technology, to automatically examine all PA requests submitted via the Provider Portal and identify which PA requests can be instantly approved, considering the provider, procedure, practice, patient, and other characteristics of a particular PA, when compared to historical PAs.

"Nebraska Total Care has been a great partner in taking care of my patients. Their payments are accurate and timely and the Pharmacy team is easily accessible for any questions. NTC is fastidious in helping their members in gaining access to needed diabetes supplies and medications covered under the Value Add formulary. It has been a pleasure working with Nebraska Total Care."

– Aaron Fredricks, Pharm D, Director of Pharmacy Operations, Diabetes Supply Pharmacy

Listing of Services Requiring PA. We never require PA for emergencies, EPSDT screenings including dental, or continuation of covered services for members transitioning into Nebraska Total Care. Our PA List is provided in **Attachment B.82 PA List**.

How We Communicate PA Requirements to Providers. Nebraska Total Care Provider Relations staff provide training for providers on authorization requirements and procedures in new provider orientation, through webinars, in town hall forums, and in person. We provide PA information in the Provider Handbook and a quick reference guide that includes a summary of PA information. As described above, we provide a ***PreAuth Check tool*** on our website where providers can quickly determine if PA is needed by entering a CPT code. We offer providers an opportunity to request an informal reconsideration or peer-to-peer discussion regarding adverse determinations with our Medical Director or other appropriate specialties clinical reviewer. We communicate this option to the provider at the time of verbal notification of the denial and include it in the standard Notice of Action letter template. We communicate PA requirement changes 30 days before implementation by posting updates on the Provider Portal, via electronic alerts, and in Provider Newsletters.

Nebraska Total Care constantly looks for ways to improve the effectiveness and efficiency of our UM procedures. For example, in 2022, based on an analysis of PA approvals for physical, occupational, and speech therapy, we changed authorization requirements, allowing the first 12 sessions of therapy per discipline to be automatically authorized. This

Figure 82 Updated PA Requirements for Therapy

News

Update: PT/OT/ST Service Authorization Processes

Date: 03/28/22

Heritage Health (Medicaid):

Effective April 4, 2022, Nebraska Total Care will update the PT/OT/ST authorization processes for Medicaid services as follows:

For all Nebraska Total Care Medicaid members we will allow the first 12 sessions, per discipline, for a new episode of care to be administratively authorized to expedite services and allow for immediate access to care. There are no changes to our evaluation auth processes, and the evaluation remains a distinct service not included in these 12 initial sessions. Evaluations continue to be able to be billed on the same day as services.

- Admin Authorization may be called in by the provider, sent in via fax or via the provider portal with the required Medicaid OTR forms until June 30, 2022
- Effective July 1, 2022, the above processes to support administrative authorization will be retired. At that time our systems will be set up to enable the first 12 sessions, per discipline, for new episodes of care to be done without any administrative authorization
- For services beyond the first 12 sessions, providers will submit authorization requests with clinical information via the same processes that have historically been in place

If you have questions, please contact Provider Relations.

change decreased the burden on providers and removed delays in access to care. We communicated this change to providers using the news bulletin provided in **Figure 82**, by email, and in person during Provider Relations staff visits.

How We Communicate PA Requirements to Members. We inform members about PA requirements on our website, in the Member Handbook, and through interactions with Member Service Representatives (MSRs). The Member Handbook includes a benefits grid that provides details on PA requirements. Our documents make it clear that members are not held financially accountable for PA requirements as this is the accountability of their provider. The member is held harmless for the financial impact of services that are denied unless they work with the provider to self-fund a service that was denied.

How We Work with Advocacy Groups on PA Requirements. Nebraska Total Care works with providers and community organizations to obtain their feedback and perspectives, and educate them on PA requirements, to meet our members' needs promptly. Below are two examples of our work in this area.

Providing Resources for DME vendors and Therapy Providers. Nebraska Total Care created a State-approved provider resource to assist our DME vendors in submitting requests for complex rehab equipment. This resource was originally provided to our large DME vendors with live training. We continue to provide this resource to DME vendors and therapy providers completing complex equipment evaluations and making the resource available on our website.

Our UM Team Supports 'Noah's' Independence. 63-year old member, Noah, had suffered an embolic stoke which resulted in quadriplegia, tracheal stenosis, aphasia, and chronic systolic heart failure. Noah's stroke left him unable to communicate verbally and he directed his care using a letter board. Because his physical limitations meant he was unable to use a traditional wheelchair, Noah's provider felt he would benefit from a Group 3 Power Wheelchair (GPW), which would allow Noah to drive his wheelchair via eye gaze and use an Augmentative Communication Device to communicate independently. Due to the GPW's new technology, our Chief Medical Director (CMD), Therapy Supervisor, and Therapist Reviewer held a case conference with Noah and his family, the DME vendor, and Noah's PT/OT providers to discuss Noah's needs, evaluate reliability data, and observe Noah successfully using the GPW. Our CMD approved the GPW and Noah is now independently mobile and can better communicate his needs and wishes.

We developed a State-approved ***Frequently Asked Questions*** resource available to our therapy providers. This resource discusses the steps in the prior authorization process, includes information regarding medical necessity criteria, and is updated to reflect any new changes to our therapy authorization process. This tool is posted on our website, sent out to our providers after individual education calls, and used by Member Services to assist in answering member questions about therapy. This tool supports formal training facilitated by Provider Relations and the Nebraska Total Care PA leadership with our therapy providers across the State.

83. Describe the Bidder's process for conducting concurrent reviews for inpatient services for physical health and behavioral health, including hospital, rehab, and skilled nursing. ***Page Limit: 2***

Concurrent Review Process for Inpatient, Rehab, and Skilled Nursing Services

Nebraska Total Care has an established system of concurrent review to monitor medical necessity for inpatient services for Physical Health (PH) and Behavioral Health (BH) including hospital, rehab, and skilled nursing services. Concurrent review is based on nationally recognized, commercially available criteria approved by our Clinical Advisory Committee (for example, InterQual Connect™ for PH and BH inpatient services and ASAM for substance use services). InterQual and ASAM criteria guide our clinical staff in determining the most appropriate level of care based on the severity of illness, comorbidities and complications, and intensity of services being delivered while considering individual member conditions and needs and the local delivery system. Our process provides for multiple-day approvals in cases where care is reasonably expected to last more than one day. From 2020 to 2021, our timeliness for concurrent reviews demonstrated:

- Medical inpatient reviews met timeliness standards 97% of the time, with a 50% increase in the number of reviews.
- Reviews for BH stays met timeliness standards 99% of the time, despite a 40% increase in volume.

Concurrent Review Staff. Working under the direction of Nebraska Total Care's Medical Director, our Concurrent Review Clinicians (CRCs) are Nebraska-licensed Nurses with recent experience in acute care settings. For BH services, CRCs consist of Nebraska-licensed BH clinicians (LCSW, LPC, Licensed Ph.D./PsyD, or Psych RN) with recent experience in a BH or substance use acute care setting. We train CRCs in medical necessity criteria application, to ensure services provided are covered, medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting.

Notification of Admission. Through our participation in CyncHealth, we electronically receive ADT notifications which we use to enhance Care Coordination with our providers and care teams. We are piloting the automated creation of inpatient prior authorization (PA) requests with our network provider Great Plains Health, based on the admission/discharge/transfer (ADT) data from their electronic health record (EHR), sent to us via CyncHealth. In this pilot, when our TruCare Cloud UM system receives an inpatient admission ADT event notification, TruCare Cloud automatically builds an inpatient authorization request from the hospital, saving the provider the need to file a PA request. Upon successful completion of this pilot, we will introduce this capability to other network hospitals.

Easing Provider Burden through EHR Use. Today, our clinical staff securely access the EHR systems of several network hospitals to perform concurrent reviews for members in inpatient care. Our use of network provider EHRs improves timely access to the most current clinical information for our staff, ensuring timely reviews. It streamlines the concurrent review process, and determination timeline, and alleviates the burden on hospitals to produce clinical documentation needed for review. We are introducing new integrated workflows in support of Emergency Department (ED) hospital event notifications using automated, real-time ADT transaction feeds to automatically create a task for appropriate UM follow-up. Upon notification of admission, our staff conducts concurrent review with direct access to the provider EHR.

Conducting Concurrent Reviews. CRCs use our daily Inpatient Census Report populated by authorizations created in TruCare Cloud to manage their daily reviews including rehab and skilled nursing stays. The Inpatient Census Report includes the member's admission date, next review date, and anticipated discharge date, allowing our staff to ensure timely concurrent reviews. Our CRCs obtain clinical information from the facility and apply both clinical inpatient and level of care criteria to determine ongoing medical necessity for admission. Clinical reviews are completed with each initial admission and every concurrent review. During the concurrent review process, CRCs assess the member's clinical status, determine the appropriateness of treatment rendered, verify the need for continued hospitalization or transition to a lower level of care, and monitor the quality of care to verify professional standards of care are met. CRCs monitor for sentinel events and potential quality of care concerns by gathering initial data, addressing immediate concerns with the Medical Director, and referring to the QI department, as appropriate.

Frequency of Review. Concurrent reviews for inpatient, rehab, and skilled nursing stays are conducted throughout the stay, with each day approved based on a review of the member's condition and medical necessity evaluation. Concurrent review frequency is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity. For members expected to have a long length of stay, such as a NICU stay, the CRC provides multiple-day approvals, with the Medical Director's agreement. All inpatient cases with a length of stay longer than ten days are discussed in our weekly inpatient case rounds.

Determination and Notification of Authorization. The CRC reviews clinical information and makes determinations within one calendar day of notification or one calendar day of the next review date for ongoing reviews. For PA requests that meet InterQual/ASAM criteria, the CRC notifies the hospital staff verbally of the approval and documents the rationale and notification in TruCare Cloud. When an authorization request does not meet medical necessity criteria, discharge criteria

are met, and/or alternative care options exist, the CRC communicates this information to facility staff. If the provider does not feel the member can be discharged or moved to a lower level of care, the case is referred to the Medical Director for review and final determination. Only the Medical Director can make an adverse determination, including denial or reduction in the amount or scope of service requested. If the Medical Director makes an adverse determination, the CRC contacts the provider to verbally notify them of the decision and offer them an opportunity to request a peer-to-peer discussion with our Medical Director or other appropriate specialties clinical reviewer. The CRC documents the verbal notification in TruCare Cloud and generates the written notice of adverse determination to the member and provider. For denials or partial approvals of preservice requests related to skilled nursing facilities and acute rehab, we notify the facility/provider and send a letter to the provider and the member.

Discharge Planning and Transition of Care (TOC). Our CRCs begin discharge planning as early as possible to identify referrals or services that need to be arranged and support the member's safe discharge to the lower level of care. As part of the discharge planning process, our staff:

- Identify and help resolve barriers to care
- Coordinate home health and DME needs
- Encourage medication adherence and assist with scheduling follow-up appointments
- Complete referrals to appropriate community agencies
- Discuss when to contact PCP, ED, and/or urgent care, and what is considered a true emergency

As part of discharge planning, our CRCs use information from the member, facility, and treating providers to identify individuals at increased risk for readmissions, such as members with complex medical and social needs, co-existing PH and BH conditions, fragile infants (NICU), and members with a history of non-compliance or poor community support. For members identified as moderate or high-risk for post-discharge complications, the CRC engages the member's assigned Care Manager or makes a referral to Care Management if the member is not already engaged. Based on assessment findings, the Care Manager works with the member and hospital staff to develop a transition plan that addresses identified barriers. This may include recommending that the attending physician order home care services or DME; setting up homemaker services; involving community agencies to help obtain support for paying utilities or home modifications; educating the member's family or friends on post-discharge care; arranging for in-home delivery of medications; connecting members with resources for food insecurity; coordinating transportation for appointments. The Care Manager authorizes and assists with coordinating covered and community services and communicates with the member's providers.

84. Describe the Bidder's process for conducting retrospective reviews to examine trends, both favorable and unfavorable, in utilization. ***Page Limit: 2***

Retrospective Review Process

As part of the UM program, Nebraska Total Care has processes and procedures in place that govern the retrospective review and identify and address utilization trends, issues, and problems, including claims denied payment for all levels of care and all patient populations. These processes are approved by MLTC and reviewed/updated annually by Nebraska Total Care.

Retrospective Review for Authorization of Services. Nebraska Total Care does not retroactively authorize routine services, except in cases where one of the valid extenuating circumstances is documented. These include services that were authorized by another payer who subsequently determined member was not eligible at the time of services; the member received retro-eligibility from the Department of Health and Human Services, Division of Medicaid and Long-Term Care; services occurred during a transition of care period between two Heritage Health MCOs, or the member was not capable of providing insurance information on receipt of the service due to incapacitation.

Retrospective Review to Analyze Favorable and Unfavorable Trends. Using our Centelligence reporting and analytics platform, we monitor, review, and analyze utilization data including Physical Health (PH), Behavioral Health (BH), dental, and pharmacy services across inpatient and outpatient settings. For example, length of stay data, inpatient acute care days or discharges, readmissions, Emergency Department (ED) visits by member and provider, PCP visits, pharmaceutical and poly-pharmacy use, referral to ancillary providers, EPSDT services and preventive service rates, provider practice patterns, and super-utilizers. Standard (monthly, quarterly, annually) and ad hoc reports are reviewed by designated UM staff and presented to the UMC and QAPIC at least quarterly. We analyze a variety of utilization data at aggregate and detailed levels to fully understand the utilization trends of members and providers, and underlying causes including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. We use an authorization analytics tool to evaluate authorization outcomes and identify services that should be added or removed from authorization requirements. We establish benchmarks using industry standards, national Medicaid HEDIS averages, or State-specific thresholds. We develop internal benchmarks based on historical data that reflect variances in population and member demographics, seasonal variations, cultural disparities, and regional characteristics.

Identification of SDOH Trends during Retrospective Reviews. The Centelligence reporting and analytics platform provides online Social Determinants of Health (SDOH) KPI Dashboards with drill-down capabilities. The SDOH KPI Dashboard aggregates SDOH data from claims and assessments to analyze member patterns and trends in social barriers to care. It shows SDOH screenings completed by month and members with SDOH needs by category, including employment, housing, and education. The Dashboard allows us to impact cost and utilization by SDOH category. For example, users can view the average cost of PMPM or ED visits for members facing housing barriers. It allows users to analyze SDOH needs by population segments, such as age, race/ethnicity, and gender, and by the provider and Value-Based Purchasing agreement.

Analyzing Inappropriate Utilization Trends. We analyze utilization trends at the system and individual levels using processes based on clinical decision support, claims and outcomes data, and medical record audits of network providers. For example, when analyzing emergency services utilization, the clinical leadership team reviews monthly reports on top ED diagnoses and members with high ED utilization. Staff evaluates the total number of visits and utilization concerning admissions and readmissions, pharmacy use, and/or the presence or absence of physician office visits. We look for patterns of under or overutilization by providers and members. We use this information to target member and provider outreach, engagement, and education, provide gaps in care reports, and identify members for inclusion in our ED Diversion program. As trends are identified, further qualitative analysis, including analysis by product and provider or practice site, helps determine potential reasons for results and formulate effective interventions. For underutilization, we analyze preventive care services, including EPSDT and routine screenings for chronic conditions. We identify members who underutilize treatment services, such as low use of controller medications in members with asthma. Members identified with a pattern of overutilization of acute care services may be underutilizing lower levels of care, preventive services, or BH services. Once identified, we engage the member in education and support.

Cost of Care Workgroup. We host a multidisciplinary Cost of Care workgroup supported by Centene's Corporate Analytics division that meets monthly to monitor and review cost of care and utilization trends. We investigate trends that are favorable or unfavorable to the cost or quality of health care, with further analytics and careful consideration of cost and utilization drivers. For example, in April of 2022, the Cost of Care workgroup identified an increase in the cost of ambulance services in Nebraska, increasing from $1.95 PMPM in 2019 to $2.03 in 2020, and $2.45 in 2021, without a parallel increase in ED use. Upon deeper investigation, the group identified that 82% of the PMPM cost was for emergent transportation to a

hospital and 18% was for non-urgent trips. This raised the discussion of how to encourage more economical non-urgent transportation such as Saferide, instead of ambulance services. Since this is very recent (April 2022), we are currently working to develop interventions to encourage non-emergency transportation options. This group looked at frequent ambulance users for trends and opportunities for intervention. The top three users had 50, 32, and 31 rides, respectively, within 12 months. The most common reasons were alcohol intoxication, altered mental status, and pain. All frequent users were referred to and engaged with Care Management, and PCPs were engaged to help manage the excess utilization. All departments have a list of conditions that require referral to Care Management, which now includes the use of ED or ambulance services for non-urgent conditions. Care Managers work with members to stabilize their condition, address SDOH, educate the member on non-emergency transportation and health care options, and work with the member's care team on ways to improve outcomes.

Avoidable Admissions/Readmissions. We regularly review reports on admissions and readmissions that were avoidable or potentially avoidable to identify interventions for improved outcomes. Lack of medication adherence, specifically discontinuing medication, has been strongly linked to a risk of ED utilization and inpatient admissions, especially for people with co-occurring conditions. Our clinical team works with providers and facilities to identify and educate members at risk for non-adherence by using pharmacy claims data, combined with PH and BH claims data, and will add dental data.

Retrospective Review to Address Quality of Care Issues. Our UM staff reviews information from claims, Nebraska Total Care staff referrals, member grievances, and external sources such as information from MLTC and providers to identify the quality of care concerns. Our quality team and the Medical Director investigate concerns to decide on the severity and need for corrective action. The QAPIC reviews the quality of care and service issue data trends quarterly and may recommend corrective action for specific providers or improvement activities that could include training. The UM department reviews quarterly reports of measures such as rates of occurrence for certain diagnoses, pre-term delivery, NICU admission, re-admission, complications of care (sentinel events), never events, inpatient lengths of stay, and relevant HEDIS measures to identify potential gaps in needed services. When potential gaps are identified, QI staff work with UM and Care Management staff to evaluate case studies and determine whether medically necessary services are being provided. Staff track claims data back to the case to identify how to improve services.

The Quality of Care Process Ensures 'Tanya' Receives Mobility Supports. Nebraska Total Care member, Tanya, had a history of obesity and was residing in a skilled nursing facility (SNF). During a concurrent review, our physical therapy (PT) UM reviewer submitted a potential quality of care concern after becoming concerned that the SNF was not meeting its care obligation for Tanya as she was unable to fit in a regular wheelchair and was instead being transported from room to room in a bariatric recliner. The SNF submitted a request for a new wheelchair for Tanya, however this was denied as Tanya did not require a custom wheelchair. Per Nebraska's Admin Code Chapter 12, SNFs are responsible for providing non-custom wheelchairs for residents' use. Upon investigation, we determined there were multiple options for K0007 extra heavy-duty wheelchairs that would fit Tanya and that the SNE could rent or purchase for her use. We notified the SNF of their responsibility to provide an appropriate wheelchair for Tanya and discussed potential wheelchair options. After confirming the SNF purchased an appropriate wheelchair for Tanya, the case was resolved.

Provider Practice Patterns. We assess provider practice patterns in several ways for potential aberrant practice behaviors including the examination of aggregate and provider-level compliance with Medicaid requirements; preventive health and clinical practice guidelines; utilization trends for inpatient, emergency, pharmacy, and outpatient PH and BH services; and factors such as appointment access and after-hours availability, authorization and billing practices, and appropriateness of services. During our review, we use our Centelligence platform, claims and outcome data, and medical record audits. We track member complaints regarding providers and potential quality of care and service events. When the potential quality of care gaps are identified, we analyze data to determine if medically necessary services are being provided. Aberrant practice patterns are often detected through suspicious billing trends identified by specialized fraud waste and abuse (FWA) software used in our claims adjudication process. If an aberrant provider practice pattern is confirmed, UM staff refer the practitioner to Provider Relations, with the participation of the Medical Director as required, for discussion of the identified pattern, comparison to peer performance, and any evidence-based relevant guidelines. If analysis identifies an issue requiring intervention, a corrective action plan (CAP) is developed within 30 days, for approval at the next scheduled UMC. CAPs are developed with providers and implemented within 30 days of creation. Six months after CAP implementation, data is analyzed to determine impacts. If the issue is unresolved, the CAP is reassessed, revised, and a date for re-evaluation is established. The UMC may decide that the CAP should be extended. If at the end of an extension the issue remains unresolved, the Credentialing Committee will make recommendations within 15 days of receipt of the summary.

85. Describe the initiatives the Bidder will implement to control inappropriate ED utilization, avoidable hospitalizations, and hospital readmissions. Discuss how the Bidder will ensure that care is provided in the most appropriate and cost-effective setting. Include strategies that address access to and utilization of:

- *Primary care and other clinic services*
- *Urgent care centers and retail clinics*
- *Discuss targeted interventions for patient populations, such as:*
  - *Asthma*
  - *Dental complaints*
  - *Chronic pain*
  - *Mental and Behavioral health conditions.*

Page Limit: 6

Initiatives to Control Unnecessary and Avoidable Use of Services

Our members experience fewer inappropriate ED visits and avoidable admissions and readmissions as a result of Nebraska Total Care's wide variety of established and new innovative programs and initiatives to ensure care is provided in the most appropriate and cost-effective setting. Our programs reduce inappropriate use and duplication of health care services through a comprehensive approach:

- Early identification of Physical Health (PH), Behavioral Health (BH), dental, health disparity, and psychosocial issues through initial and ongoing member screening and assessment, data mining, review of monthly reports, and predictive modeling using Centelligence, our reporting and analytics platform
- Risk stratification and targeted interventions to maximize the impact of Care Coordination
- Innovative Care and Disease Management programs that improve health outcomes through individualized treatment plans, timely referrals to providers, and identifying and overcoming barriers to care
- Resources and support for members/caregivers including in-person assistance through our Community Health Workers (CHWs) and linkage to community resources to address Social Determinants of Health (SDOH), such as stable housing
- Care Coordination and referrals, telephonically or in-person, depending on member acuity, to facilitate access to all needed services and supports. This includes scheduling assistance, monitoring, follow-up, and appropriate methods of assessment, referral, and coordination with other State programs
- Effective transition of care planning and post-discharge follow-up to reduce readmission
- Strategies to align provider and MLTC goals via Value-Based Purchasing contracts and targeted incentives
- Working with providers, community agencies, and advocacy groups to address member inequities/SDOH

Inappropriate ED Use. Our Emergency Department (ED) diversion program discussed in Question V.N.80, provides outreach and education to members on appropriate ED use and alternatives, covered benefits, availability of support services, and chronic condition management, including planning for medication refills before the end of the prescription. Our CHWs meet with members by phone and in person, educating them on appropriate ED use. ***This program is highly effective, reducing ED utilization by 27.2% between 2017 and 2021.***

BH Onboard. In partnership with first responders, we are delivering on-demand access to BH crisis stabilization to prevent unnecessary ED visits. We will equip the first responder with cellular-enabled digital tablets and a virtual visit platform giving first responders a 24/7 ride-along BH professional to support any Nebraskan in crisis.

Telehealth Solutions. We are implementing several telehealth solutions to improve access to health care, especially in rural parts of Nebraska. These solutions, which include Babylon 360 and Brave Health, support members with urgent care, primary care, dental, and BH needs.

Partnering with Providers. Provider Relations, Contracting Staff, and Care Coordinators meet with providers to leverage combined resources and develop viable action plans that reduce ED visits for members with high utilization. We host member-specific multi-disciplinary care conferences for super-utilizer members to identify causes and motivation for ED visits and problem-solve for interventions and solutions. These have been highly successful in reducing ED utilization.

ConferMED. We will support providers with ConferMED Specialty eConsult solution, which enables asynchronous consults between PCPs and specialist providers to expand access, decrease service wait times, and reduce avoidable specialist visits, tests, and procedures. Historically, 80% of eConsults result in a recommendation that avoids specialty care visits, supporting members in getting the care they need at the right time, without unnecessary visits. Nebraska Total Care utilizes eConsults to promote and support efforts that integrate primary care services within specialty BH settings and support primary care-based BH for pediatric populations.

Reducing Avoidable Readmissions. Our concurrent review team reviews all readmissions within 30 days for appropriateness. If the readmission did not meet medical necessity criteria, we will review and respond following CMS and MLTC guidance. Members will never be held financially liable. Our Transition of Care (TOC) program described in Question V.M.80 assesses members for high risk of readmission and facilitates effective TOC between service settings, using an approach founded on the evidence-based TOC Model first published by Eric Coleman. The program provides proactive transition planning and intensive support to engage members in their care after discharge, preventing and reducing readmissions for members with high risk. 4,748 members participated in the TOC in 2021.

Ensuring the Most Appropriate and Cost-Effective Setting

We ensure members are served in the most appropriate and cost-effective setting of care by leveraging evidence-based practices and national criteria. We perform prior authorization for services that can be favorably impacted by ensuring requests meet medical necessity for the most appropriate setting of care. We monitor for over and underutilization of services by specific region, facility, provider, member, and diagnosis to identify patterns and implement interventions.

Engaging Members as Partners in Care. Member engagement is a key factor in controlling avoidable hospital and ED use and improving health outcomes. Nebraska Total Care uses evidence-based engagement strategies, such as motivational interviewing, to provide person-centered, culturally sensitive outreach and education to members, helping them direct their care based on what is important to them.

Member Tools and Incentives for Appropriate Utilization. We promote our 24/7 Nurse Advice Line (NAL) to all members, using a variety of written, online, and in-person methods. We understand that some areas of Nebraska lack good Internet access, but for those with access, our Member Portal provides a wide range of information about Nebraska Total Care services, self-management tools, and the member's plan of care. Our mobile applications provide easily accessible information to support appropriate utilization and personal responsibility for health. For example, our MyNTC Member Mobile App provides health and wellness resources and health alerts.

Digital Health Connect extends Care Management resources and drives deeper member engagement, self-care, and secure HIPAA-compliant communication between members and their care team. The app deploys condition-specific member programs (maternal health, diabetes, and other chronic conditions) and provides real-time progress and clinical alerts to Care Coordinators enabling easy two-way messaging. Each program consists of a targeted curriculum to help boost engagement and member self-management. The app gives our teams new tools to reach more members more frequently, make evidence-informed decisions, improve outcomes, and reduce health disparities. ***Digital Health Connect supports high member engagement, with 75% of participating members interacting with the program weekly and an 80% member satisfaction rate***.

My Health Pays® is our member incentive program that offers financial rewards to members actively engaged in healthy behaviors and decision-making based on local trends, State priorities, and past performance. Eligible members can earn rewards for completing annual preventive health visits and recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. My Health Pays rewards can be used to cover payments for childcare, telecommunications, utilities, education, rent, transportation services, and eligible purchases at any Walmart.

Access to Primary Care and Patient-Centered Care Approaches

Nebraska Total Care promotes member choice in selecting a PCP/medical home. We understand that members are more likely to utilize care appropriately when they choose and establish a PCP relationship and when their plan of care is person-centered and based on their goals and preferences. We educate members early about the importance of medical homes, beginning with our new member materials and welcome call. Our Member Service, NAL, and Care Coordination staff help members select an appropriate and convenient provider that fits their cultural and language preferences, and assist with PCP changes, as needed.

Supporting the Medical Home. We educate and contractually require PCPs to manage and coordinate members' PH and BH needs, and consider dental and pharmacy needs, to ensure all medically necessary services are available promptly. This includes developing plans of care to address risks and medical needs and coordinating care with other providers. We educate and require PCPs to meet MLTC-required appointment scheduling standards to ensure members have access to the appropriate setting for preventive and primary care services and prevent the use of inappropriate settings. We educate and require PCPs to provide after-hours availability to members who need medical advice. At a minimum, we require the PCP office to have a return call system that is staffed and monitored, to ensure members are connected to a medical provider within 30 minutes of their call. We educate providers on these requirements via our provider orientation process, the Provider Handbook, written and online materials, ongoing training, and targeted education. Our VBP agreements proactively encourage the expansion of appointment availability, including extended office

hours, reduced wait times, and increased access to care, thereby reducing inappropriate ED utilization.

PCP Alerts and Reports. We provide timely information to providers about members' utilization that may affect ED use. Through our Provider Portal, PH and BH providers can access our member encounter report 24/7 to review member service utilization. In addition, our care gap reports inform the provider of members due or overdue for a well-visit, screening, or immunization. These tools support the medical-home relationship and facilitate providers' outreach efforts, enhancing their ability to succeed with VBP agreements.

Urgent Care Centers and Retail Clinics

Availability of urgent care and other easily accessible locations for non-emergent care, such as retail clinics, can reduce unnecessary ED use. We educate members about the availability of urgent care providers in a variety of ways, such as:

- Our member Welcome Packet, welcome call, Provider Directory, Member Handbook, and website
- When Care Managers work with members to complete assessments, plans of care, and member education
- When members contact the Member Services Call Center or NAL with urgent care needs
- When CHWs educate members on appropriate access to care options

Targeted Interventions for Patient Populations

Based on the evaluation of population needs, we develop, adapt, innovate, and promote programs that provide members with resources to advance their health. Members receive personalized care as they engage with targeted interventions and programs based on their needs. This helps members use health care services that prevent and manage chronic conditions, avoiding inappropriate inpatient and ED use. We offer Health Solutions for Life, our suite of accredited Disease Management programs, for members with chronic conditions including asthma, coronary artery disease, heart failure, chronic obstructive pulmonary disease, diabetes, back pain, weight management for adults, hypertension, and tobacco. Members are supported by clinical and non-clinical staff in a health coaching approach, which provides the tools and interventions needed to help individuals diagnosed with a chronic condition adopt healthy habits and decrease risk factors to slow the progression of the disease/condition. Aggregate utilization changes from 2018 to 2021 have demonstrated a positive impact, including a 32.4% decrease in inpatient admissions, 29.4% decrease in potentially preventable admissions, and 8% decrease in potentially preventable ED visits, ***indicating more appropriate utilization of preventive services.***

Reducing Health Disparities

Our Disease Management program reduced health disparities for Black members compared to White members by 73.4%. Black members experienced a 14.3% lower rate in the HEDIS quality measure AMR (Asthma Medication Ratio) compared to White members in 2018, which was reduced to 3.8% in 2020.

While Disease Management is available to all members, members with complex and comorbid PH and BH chronic and/or acute conditions are referred to Care Management staff who work with the member to assess and identify all their physical, behavioral, and social needs. They develop a person-centered plan of care by coordinating with the member's care team to implement strategies and interventions that support the member in meeting their health and wellness goals as described in Jenny's story below.

Care Management Helps 'Jenny' Better Manage her Diabetes. Jenny was referred to our Care Management team for help managing her complex physical and behavioral health conditions, including Type 2 Diabetes, COPD, respiratory failure, spinal stenosis, heart disease, and depression. Severe hand pain and trigger finger left Jenny unable to monitor her blood sugar using a glucose meter so her primary care physician (PCP) recommended a continuous glucose monitor (CGM). The request for a CGM was initially denied by the DME company, so our Care Management team partnered with our UM team and consulted with Jenny's PCP and the DME company to secure approval for the CGM. As a result, Jenny is now able to closely monitor her blood sugar and better manage her diabetes.

Asthma. The goal of our Asthma Disease Management program is to provide telephonic outreach, education, and support services to promote adherence to asthma treatment guidelines and prevent exacerbations that result in ED visits. Our Asthma Disease Management Program uses Registered or Certified Respiratory Therapist Health Coaches to develop a person-centered plan of care. Coaching is provided telephonically and in the home and focuses on proper use and maintenance of respiratory equipment, medication understanding and compliance, improving exercise tolerance, and tobacco cessation. Member education includes recognizing asthma symptom triggers and how to avoid or address them. For participants under 10 years of age, we send *The Adventures of Boingg & Sprockett Through Puffletown*, a cartoon

booklet explaining asthma and self-management; and to their caregivers, a companion guide. We provide teenage participants with a booklet called *Off the Chain – Asthma* that uses examples they can relate to, such as comparing the annual cost of smoking to items such as video games and sports equipment. A sample of our Asthma Action Plan is provided as **Attachment B.30.B Asthma Action Plan.**

Interventions for Dental Complaints. With the implementation of Envolve, our delegated dental services affiliate, Nebraska Total Care will provide integrated Care Coordination for dental concerns, including preventive health, to manage dental care for members with special health needs and SDOH. Dental-related pain is a common reason for ED utilization. Members experience less pain and ED use when their conditions are addressed promptly and coordinated with their other health care and social needs, such as transportation and housing.

Envolve focuses its interventions to avoid and mitigate dental complaints through a comprehensive network of dental homes, dental providers, and specialists to provide easy access to preventive, routine, and episodic dental services. When members understand the importance of and have access to preventive and routine dental services, the incidents of dental complaints are reduced. Our innovative strategies to promote improved access to and use of dental care will include the following:

- Dental Homes – encouraging members to have a routine and established dental provider
- School-based health clinics – providing prevention and education in schools
- Project Access – providing support to rural FQHCs to recruit dental providers
- Access to teledentistry through the NAL – members may call the NAL for dental concerns and schedule a telehealth appointment with a dental provider

Interventions for Members with Chronic Pain. Effective strategies to help members address chronic pain are an important part of our efforts to reduce ED use and prevent avoidable admissions. Chronic pain is not associated with an acute injury, lasts three months or longer, and can interfere with a member's daily activities, such as working, socializing, and taking care of themselves or others. It can lead to depression, anxiety, and trouble sleeping, which can make the pain worse. This response creates a cycle that's difficult to break and may lead to self-medicating, including legal and illegal substances. Nebraska Total Care partners with providers and community agencies to offer pain management for members with chronic pain, such as the Chronic Pain Management Program at Nebraska Medicine.

Chronic Pain Management Program (CPMP) at Nebraska Medicine. Members are referred to CPMP when the member's pain is not resolved with medical interventions, and their functioning continues to decline. Members need to be willing to try alternatives to pharmaceutical treatment options and wean off opioids. CPMP leverages a team of Physicians, Nurses, Physical Therapists, and Clinical Psychologists who assess, motivate, and educate members to help them learn new physical and psychosocial skills to manage their pain. The goal is not to relieve pain but to reduce and adapt to it through coping skills. ***CPMP has achieved encouraging results, including a 38% reduction in pain severity and a 62% reduction in depression from pre- to post-treatment.***

Sickle Cell Disease (SCD) Management. We offer a sickle cell program to support members in managing their SCD and improve hydroxyurea utilization rates, which has been shown to decrease pain crises and complications in sickle cell patients, ultimately reducing non-emergent ED utilization. From 2017 to 2021, the number of Heritage Health members with SCD who had 30 or more days in active Care Management increased by over 12%. We saw a decrease in related inpatient events, including a 22% reduction in inpatient utilization. ***From 2017 to 2019, we saw a 38% increase in the sickle cell hydroxyurea utilization rate, which indicates that our program is effective in helping members with SCD access relevant pain medications.*** We are enhancing our current program and by go-live will offer a Sickle Cell Disease Management Program (SCDMP) that deploys a team of tech-enabled Nurse Care Managers who will deliver 24/7 virtual Care Coordination, psychosocial support, and personalized mentoring to members with SCD. SCDMP staff will coach members in managing their SCD and behavioral change skills to reduce the likelihood of pain crises and infection while addressing social and environmental barriers and improving overall health.

Person-Centered Care Management Improves 'Jamaal's' Chronic Pain. Nebraska Total Care Member, Jamaal, had a history of sickle cell disease, chronic pain syndrome, and schizophrenia. Through utilization monitoring, we identified that Jamaal had visited the ED over 20 times a month and was being prescribed opioids by several providers, including pain management injections from his Hematologist and oral narcotics during each ED visit. Our Care Management team organized a person-centered care conference that included our Chief Medical Officer, Director of Pharmacy, Director of Care Management, and Jamaal's treating providers. During the care conference, we discussed Jamaal's utilization patterns, his physical and behavioral health care needs, and collaborated on a treatment plan. As a result, Jamaal agreed to an inpatient admission to detox from all narcotics and he was prescribed buprenorphine for pain control. Since then, Jamaal's ED utilization has been greatly reduced, he continues to receive ongoing care from a pain management specialist, and his pain control and overall quality of life have significantly improved.

Interventions for Members with BH Conditions. Members with BH conditions have access to our holistic programs to provide BH services in the lowest level of care appropriate to the member's condition; improve the transition to outpatient care, including 7-day follow-up care; increase medication adherence; and partner with community resources to ensure members have the support they need in their community, such as access to substance use treatment. We promote alternative BH care; for example, we train and reimburse PCPs to manage low acuity BH issues, such as using SBIRT (screening, brief intervention, referral, and treatment), an evidence-based practice for substance use disorder (SUD). We promote the use of peer support and ensure lower levels of care are available in our network. We educate providers about this service and members who may benefit from it.

BH Crisis Helpline. Members in crisis can receive assistance through our BH Crisis Helpline via IVR or warm transfer from our Member Service Representatives (MSRs). Care Managers and MSRs are trained to listen for key emergency words and phrases, caller voice volume and tone, and other indicators of stress, and facilitate warm transfers to our BH Crisis Helpline when appropriate. If necessary, MSRs will dial 911 for the caller while keeping them on the line. Licensed BH Clinicians staffing the BH Crisis Helpline complete risk assessments using the Columbia-Suicide Severity Rating Scale (C-SSRS), apply their clinical skills to de-escalate crises and connect members to follow-up care, including mobile crisis services that do not require prior authorization. If the level of risk is indicated to be urgent/emergent, the Care Coordinator contacts local providers, or the necessary authorities, to intervene as appropriate. BH Crisis Helpline staff do not end contact with the member/family until emergency services have arrived, or until referral to appropriate treatment, the provider is scheduled. Members with a score above a certain threshold on the C-SSRS are flagged within TruCare Cloud, alerting staff to assess for suicidal risk. We ensure appropriate follow-up and referrals to care for all crisis calls.

myStrength Digital Self-Care Resource. Members with Internet access can improve their mental health and overall wellbeing using our online BH resource tools, such as myStrength, a customizable self-care resource. myStrength fosters personal responsibility and healthy lifestyles by helping members learn more about their diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. Members can engage in personalized e-Learning programs to overcome BH conditions, such as depression, anxiety, overuse of drugs or alcohol, and serious emotional disturbance (SED) in a safe, confidential environment. We encourage caregivers to enroll and utilize myStrength for their support and to better understand the BH diagnosis of their child or family member. myStrength can be accessed through a computer and/or mobile application. To promote awareness of this free resource, in 2021 we launched a comprehensive email campaign encouraging members to enroll in myStrength. Over 720 members are using myStrength, with an average of 39% of users demonstrating clinical improvement over six months. We will continue to promote these resources with providers and members to increase member independence and wellbeing.

Programs for Pregnant Members with SUD. For all pregnant members, the Integrated Care Team includes nurse educators trained in prenatal and postpartum care. For members experiencing SUD, a BH Care Manager coordinates access to a full scope of services to provide for recovery during pregnancy, a healthy delivery, and a supported and equipped parent following birth. Specific attention is given to the medication assessment and ensuring a balance between the stability of the member and the safety of the baby. Each member's team also includes a certified peer recovery specialist to help address the fear of stigma when accessing care.

Delivered through our partnership with Pomelo Care, pregnant Nebraska Total Care members can receive virtual group prenatal care grounded in the evidence-based Centering Pregnancy model. Group prenatal care has been proven to reduce

preterm births by 30%. With just two accredited Centering Pregnancy sites in Lincoln and Omaha[1], Pomelo's virtual model increases our members' access to this verified approach to reducing preventable NICU stays.

Other Interventions that Support Appropriate Utilization of Services

Nebraska Total Care uses a variety of other interventions that provide access to services and supports, preventing avoidable ED use and admissions.

Safe Nebraska. Our Safe Nebraska approach offers tailored Care Management support to members experiencing violence. Members receive targeted safety planning, SMART goal setting, and Care Coordination based on their specific needs to close care gaps and link them to needed integrated health and community-based services. The interventions in this program reduce inpatient admission and ED visits and promote medication adherence while reducing and/or eliminating further self-harm activity while engaged in Care Management.

Free ConnectionsPlus Phones. These phones are provided for high-risk members to send and receive calls and text messages from their PCPs/treating providers, Care Managers, other health plan staff, NAL, and 911. We provide phones to homeless members who may not be considered high-risk but who do engage in any level of Care Management.

Friendly Call Program. Nebraska Total Care will use our predictive modeling capability to identify members who are identified as at-risk for social isolation or loneliness. Through outreach from our Care Management team, we will confirm social isolation or loneliness and prioritize members for the Friendly Call program. The Friendly Call program links local community-based volunteers that can facilitate ongoing calls with members facing social isolation who would like more social contact, creating meaningful connections across the community. This solution provides an opportunity for proactive support for members whose physical and mental health may deteriorate in isolation.

[1] "Centering Sites in Nebraska (NE)." Centering Sites for NE, https://centeringhealthcare.secure.force.com/WebPortal/ListOfCenteringSites?stateName=NE.

86. Describe the Bidder's proposed MTM program, including a description of the inclusion criteria that the Bidder proposes to use. Also, include any vendor(s) that will be subcontracted by the Bidder to perform or support MTM services. Provide a detailed description of tools the Bidder will use to ensure the active engagement of the retail pharmacies in the MTM program.

Page Limit: 4

Nebraska Total Care's MTM Program Activities

Nebraska Total Care's Medication Therapy Management (MTM) program has helped members achieve optimal therapeutic outcomes for the past five years. Developed in cooperation with licensed and practicing pharmacists and physicians, our comprehensive, person-centered MTM program strengthens members' understanding and therefore increases their adherence to prescribed medication regimens. ***More than half of the members eligible for the MTM program are already in Care Management***. The MTM program drives communication and coordination among members, pharmacists, prescribers, and Nebraska Total Care clinical pharmacy staff Care Managers, resulting in a fully integrated pharmacy benefit that delivers quality, whole-person care. The program also prevents adverse pharmacological events and curtails unnecessary, duplicative, or fraudulent pharmacy spending by monitoring prescribing patterns and treatment plans involving psychotropic medications, opioids, medications at risk of abuse, high-cost medications, and other medications identified by MLTC. We proactively identify the following to drive member-tailored interventions:

- Nonadherence to chronic medications
- Gaps in care
- Therapeutic duplications
- Opportunities to reduce cost
- Drug-age contraindications
- Drug-drug interactions
- Drug-inferred disease interactions
- Deprescribing opportunities
- Opioid misuse and other dangerous drug combinations

Quarterly Targeted Medication Reviews. A targeted review is concentrated on one or more prescribed medications for a single diagnosed condition, such as asthma, hypertension, and depression. This review focuses on the member's ability to adhere to and tolerate the therapy. If the member appears to have adherence challenges, the pharmacist offers applicable recommendations, either to the member to make therapy easier to manage or to the providers to discuss medication alternatives, as clinically appropriate.

Member Education. Through member-centered education, we continuously strengthen members' understanding of their prescriptions and therapeutic objectives. We provide numerous educational touchpoints about the pharmacy benefit, such as mailed and online materials, access to the Preferred Drug List, assistance from our call center, and education delivered by our network of engaged pharmacists. Members who understand and embrace their role in improving their health are more likely to self-advocate for their needs and adhere to their medication regimens.

Pharmacy Complex Care

82% of members enrolled in the Pharmacy Complex Care program achieved the HEDIS measures in NESP's SOW, including asthma medication ratio, antidepressant adherence, beta-blocker following heart attack, statin adherence in patients with cardiovascular disease or with diabetes, and antipsychotic adherence in schizophrenia.

MTM Vendors

Nebraska Total Care has successfully delivered MTM services to our members in partnership with experienced vendors for the past five years. We take an engaged and proactive approach to monitor vendors, including communication protocols to identify issues early should they arise. Our Vendor Oversight Committee monitors, evaluates, and oversees processes that are built from our experience and lessons learned, as well as the proven practices of our parent company, Centene, and our 29 affiliate Medicaid health plans. We will obtain approval from MLTC before entering any new MTM vendor agreements or changing vendors. Our agreements contain all relevant provisions of the SOW applicable to the delegated services.

OutcomesMTM. Through our parent company, Nebraska Total Care leverages OutcomesMTM, a national leader in retail-based MTM programs, to support our MTM program. OutcomesMTM provides an efficient platform to incentivize, engage, and train each local prospective pharmacist participant to review member records and conduct outreach to schedule face-to-face or telephonic appointments with members. ***Over 3,000 pharmacists at more than 300 of our network pharmacies are trained to provide MTM services.*** We provide OutcomesMTM with a monthly data file that identifies members for outreach. Pharmacists perform comprehensive medication reviews (CMRs) with members and document activities within the OutcomesMTM platform. Nebraska Total Care receives MTM reports for monitoring and oversight, and we have access to the OutcomesMTM reporting platform to review the results of pharmacist MTM outreach. The pharmacist delivers and

documents service using a structured interview process consisting of one of the following types of reviews, as clinically appropriate:

Comprehensive Medication Review (CMR). The improper use of multiple or inappropriate medications can lead to health complications and become cost drivers with preventable admissions/readmissions. Our MTM pharmacists conduct CMRs annually and work with members meeting MTM program criteria, caregivers, and families to develop a customized action plan to address any concerns. MTM pharmacists may discuss identified concerns with the member's prescribers, for example. Pharmacist-led CMRs include a review of members' medication histories, such as prescription drugs, Over-The-Counter medications, and supplements. The CMR also includes:

- Identification/documentation of allergies and chronic conditions
- Review of high-risk medications
- Optional documentation of health goals and measurements
- Disease state-specific questions
- Cost savings alerts (if appropriate)
- Resolution of Safety Alerts and Care Gap Alerts
- Completion of required documentation
- Delivery of member handouts, for example, the Medication Action Plan and Personal Medication List in the CMS standardized format

Targeted Intervention Program (TIP®). Identified through retrospective analyses, TIPs focus pharmacist activity on medication issues such as gaps in care, nonadherence, cost-effective alternatives, and high-risk medications. TIPs allow for consistency across the network in the intervention process, getting local pharmacists involved in making a difference for their patients in the most efficient way possible. TIPs are customized to Nebraska Total Care's integrated health care management program.

Prescriber Consultation (intervention or referral). A pharmacist consults with the prescriber and member to address inappropriate dosages for high-risk medications and gaps in therapy. Through these consultations, pharmacists and prescribers can prevent, mitigate, and resolve drug therapy problems leading to better health outcomes and cost savings.

Patient Adherence Check-in (documentation and follow-up). For members at risk of nonadherence, a pharmacist counsels the member on appropriate medication use. The pharmacist also identifies existing or potential barriers to adherence and offers solutions to assist the patient with taking the medication as prescribed.

Outcomes MTM Inclusion Criteria. Members taking at least six medications and having any three of the following disease states are eligible for inclusion in the MTM program:

- Asthma/COPD
- Bipolar Disorder
- Chronic/Disabling Mental Health
- Depression
- Diabetes
- Dyslipidemia
- Hypertension
- Schizophrenia

Serving Rural Nebraskans

A Nebraska Total Care member in Alliance, NE was frequently traveling to Colorado for specialist care for her prematurely born child with health complications and filling medications at pharmacies in both states. We engaged an NESP pharmacy in Alliance and collaborated to transfer and consolidate the medications at Dave's Pharmacy. Dave's Pharmacy provided free home delivery and medication synchronization. In addition, Nebraska Total Care assisted the pharmacy with obtaining prior authorizations for the various medication formulations needed to treat the child's complex conditions.

Nebraska Enhanced Services Pharmacies (NESP). In June 2021, we launched an innovative Pharmacy Complex Care program through Nebraska Enhanced Services Pharmacies (NESP), an affiliate of the Community Pharmacy Enhanced Services Network (CPESN). This program will provide members with high-touch, locally-delivered MTM services through a clinically integrated network of 61 independent Nebraska pharmacies. We know that local pharmacists are often a trusted source for members to obtain information and guidance regarding their medication regimens.

"NESP Pharmacies appreciate the opportunity to improve outcomes for NTC Members that we serve. We have been impressed with the coordination of IT, contracting, accounting, pharmacy services, and member outreach with our organization. Dedication to this complex care contract is evident and we feel that the data will show improved outcomes and lower overall health care costs. The contract has been part of the sustainability model needed to keep local retail community pharmacies thriving in Nebraska communities to help provide much needed medication compliance and education. We look forward to continued collaboration with Nebraska TotalCare."

– Staci Hubert, Pharm D, NESP President

NESP Inclusion Criteria. Members who take six or more medications are eligible to receive the following services from their local pharmacists:

- A comprehensive 10-step medication review
- No-cost monthly home delivery of medications in adherence packaging
- Ongoing refill management services, including refill synchronization and monthly medication reconciliation to ensure adherence
- Ongoing member and provider outreach to address gaps in care

We reimburse NESP pharmacies on a per utilizer per month basis. We incentivize positive outcomes by providing a bonus payment for meeting HEDIS pharmacy measures such as Asthma Medication Ratio, Anti-depressant Adherence, Beta-blocker Adherence after Heart Attack, and Statin Medication Adherence in Cardiovascular Disease or Diabetes, and Antipsychotic Adherence for Schizophrenia. **Our NESP partnership exemplifies our local, collaborative approach to MTM to drive outcomes while supporting locally-owned pharmacy businesses.**

Tools to Increase Retail Pharmacy Engagement In The MTM Program

We offer our retail pharmacies tools, education, and training resources to drive active engagement in the MTM program. Currently, over 3,000 network pharmacists are trained to deliver MTM services to our members, and this level of engagement has helped to achieve pharmacy spend cost savings of $1,131,915 in 2021. In **Table 86** we describe the tools and resources that successfully engage retail pharmacies to participate in the MTM program:

Table 86 Tools to Engage Retail Pharmacies

Tools	Descriptions
Alternative Payment Models	Through payment agreements with our MTM program vendors, we incentivize retail pharmacies to actively engage with members. In addition to reimbursements for MTM services, we provide additional bonus payments for achieving HEDIS medication adherence measures and an administration fee for long-acting injectable antipsychotics administered by a pharmacist.
Monthly Opportunity Reporting	In addition to alerts provided to all pharmacists within the OutcomesMTM platform, we provide NESP with a monthly report of open MTM opportunities to engage NESP pharmacies to conduct MTM services for members
Pharmacy Education	We send letters, faxes, and newsletters, and place alerts on patient safety or drug concern issues by the Food and Drug Administration, including customized communications regarding our MTM Programs and how members may access those services.
Pharmacy Training	Our MTM program includes health plan-approved training materials such as processes and procedures for delivering MTM services at the POS and in the community, including how to interact with their members in the MTM program.
Peer To Peer Consultation	Nebraska Total Care registered pharmacists engage in peer-to-peer consultations requested by the prescriber following prior authorization and appeal denials for drugs covered under the pharmacy and medical benefit.
Prospective DUR-POS Alerts	POS messaging alerts pharmacists of potentially dangerous drug contraindications and prompts them to use professional judgment in dispensing if there are soft edits.
Supermarket Pharmacist Diabetes Management	We will compensate supermarket pharmacists for managing members' diabetes through a holistic, personalized approach. This approach will consist of: • Educating members about medication adherence

Tools	Descriptions
	• Engaging prescribers when inappropriate or potentially harmful drug combinations can pose a risk or interfere with the diabetes drug regimen • Conducting HbA1c testing and other point-of-care tests and screenings to close care gaps. • Coordinating with dieticians to provide education, including a personalized in-store consultation for better food choices

87. Describe the Bidder's DUR program including prospective and retrospective DUR activities. Include a description of:
- *Prescriber and pharmacy education programs.*
- *Collaboration with MLTC's DUR.*
- *How DUR results will be used to inform MTM education and outreach.*

Page Limit: 3

Nebraska Total Care's Drug Utilization Review (DUR) Program

Nebraska Total Care's DUR program reviews analyze and interpret prescribing and utilization data against established medical standards and criteria. Our DUR program meets all Federal and State requirements, the CMS Annual DUR Report requirements, and the requirements outlined in Section V.N.10 of the SOW. We integrate prospectively and retrospective analyses to monitor and identify outlying prescribing practices, inappropriate utilization of opioids and other drugs with abuse potential, off-label drug usage, and curtail unnecessary, duplicative, or fraudulent pharmacy spending. In addition, we leverage our DUR program to identify opportunities to increase access to needed medications. For example, ***we lifted the PA requirement for Vivitrol to increase access to a substance use disorder drug that helps lower relapse rates and readmissions.***

Prospective Activities. DUR edits applied at the point of sale identify and prevent potentially unsafe utilization. Our pharmacy benefit manager's point of sale system will continuously draw from the Medi-Span® clinical database to obtain updated, comprehensive drug information for prescription and over-the-counter drugs and process all edits concurrently. In addition, the point-of-sale system will establish and maintain retrospective exception criteria and process prospective DUR safety edits.

Point of Sale Messaging. The point-of-sale system will alert pharmacists of potentially dangerous drug contraindications. Pharmacists may use professional judgment to override soft edits by submitting a submission clarification code that allows the claim to be processed. Pharmacists cannot override hard edits that stop the claim at the point of sale. For example, an opioid prescription for a member concurrently using two long-acting opioid analgesics would not adjudicate due to potential duplication in therapy, increased risk of central nervous system depression, and possible opioid overdose. This prescription would need prior authorization to process. Depending on the risk to the member, the pharmacist may contact the prescriber and recommend alternative drug therapy.

DUR Program Success

Since 2017, we reduced opioid prescriptions by 48% per thousand members coupled with a combined savings in 2019 and 2020 of $2.1 million in opioid spend without compromising specific member needs for pain management.

Retrospective Activities. Nebraska Total Care's clinical pharmacy team retrospectively analyzes drug utilization data to identify:

- Inappropriate prescribing practices
- Overuse of drugs with the potential for abuse
- Adverse drug events
- Cost-effectiveness
- Potential fraud and waste
- Other drug hazards

Care Managers participate in retrospective DUR to provide additional information and identify members whose utilization patterns indicate a need for a substance use disorder assessment. We offer thoughtful interventions and referrals for other services based on the information obtained during retrospective DUR. We conduct at least one retrospective DUR intervention each quarter of the contract year and submit to MLTC the final analysis and report. Drugs on MLTC identified state exclusion list are permitted exceptions to these retrospective review activities.

"Nebraska Total Care is a godsend for my patients. You are amazing to work with, regardless of whether it is an inpatient authorization or removing barriers to care. When Nebraska Total Care removed prior authorization for IM Vivitrol, it was a godsend for my patients with opioid addiction and alcohol addiction. I've noticed that patients who receive long acting medications have a much easier time with relapse prevention, and I'm not seeing the readmissions related to medication noncompliance."

- Dr. S. Pirzada Sattar, Medical Director, Inroads to Recovery

Compliance With SUPPORT Act. We have implemented provisions with our DUR program to align with the SUPPORT Act consistent with section 1902(oo)(1)(A)(ii) of the Social Security Act, and Section V.N.10.c. of the SOW. For example, through our automated claims review process, we place safety edits on opioid fills that are over state limitations (duplicate fills, early fills, and drug quantity limitations), above 90 Morphine Milligram Equivalent (MME) dose limitations, and concurrent

prescribing of Dangerous Drug Combination, such as opiate and benzodiazepine, opioid and antipsychotic, or two central nervous system depressants. These edits prompt the dispensing pharmacist to attest to the point of sale DUR reject and override the soft edits with pharmacy professional service codes. Monthly retrospective DUR reports identifying members concurrently taking opioids and benzodiazepines are reviewed for prescriber trends, and provider outreach is conducted as appropriate.

Prescriber and Pharmacy Education Programs

Based on experience and long-standing relationships with Nebraska providers and pharmacists, we know most prescribers and pharmacists will self-correct inappropriate or aberrant prescribing or dispensing practices when provided with educational programs that strengthen their prescribing and dispensing decision-making. We collaborate with our prescribers and pharmacists through Vendor Oversight Committee meetings with providers in value-based arrangements to ensure they have the data, resources, and education to make appropriate, cost-effective prescribing decisions. Our educational programming is detailed in **Table 87 Prescriber and Pharmacy Education Programs**.

Table 87 Prescriber and Pharmacy Education Programs

Education Program	Description
Buprenorphine Waiver Training	We provide free training, such as the American Society of Addiction Medicine's Opioid Use Disorder training, to help providers qualify for the DATA 2000 waiver to prescribe buprenorphine for opioid addiction.
Opioid Resources Webpage	Our Opioid Abuse resource webpage provides opioid-specific educational resources, including links to the Centers for Disease Control opioid prescribing and tapering guidelines, American Medical Association recommendations regarding naloxone, and information about the Nebraska Prescription Monitoring Program (PMP) tool.
Narcan Education Program	**Narcan Education Program.** Every two days, someone in Nebraska dies from a drug overdose[1]. This program will help prevent opioid-related overdoses. We will identify members who have presented at EDs with an opioid overdose and engage their providers to prescribe Narcan through retrospective DUR reports. As needed, we will follow up with members to encourage Narcan utilization.
Provider Outreach Campaigns	We educate prescribers about the risks of polypharmacy and other drug-related problems through letters, faxes, emails, and in-person meetings. New for this contract, we will deploy campaigns about statin use for cardiovascular disease and diabetes, the importance of medication adherence for chronic conditions, and care gaps for Rheumatoid Arthritis and Osteoporosis.
Provider Prescribing Scorecard	Our innovative Scorecard offers prescribers a line of sight into their prescribing patterns, measured against peers and industry standards. The Scorecard will enable them to self-correct, improve their prescribing practices, and deliver appropriate medical care.
Nebraska Prescription Monitoring Program (PMP)	We educate our prescribers through Provider Bulletins, Vendor Oversight Committee meetings, and Town Hall discussions to check the PMP before prescribing CII controlled substances as required under Section 5042 of the SUPPORT Act.
Peer-to-Peer Consultation	Our Pharmacists and Medical Directors offer peer-to-peer consultation to review prescriptions, guidelines, and utilization trends against clinically sound and cost-effective care.

Collaboration with MLTC's DUR Program

As an original Heritage Health partner, Nebraska Total Care has a track record of collaborating with MLTC's DUR Board to improve the DUR program. We evaluate the effectiveness of member, prescriber, and pharmacy educational interventions and submit analyses of cost outcomes to MLTC. Nebraska Total Care Pharmacy Director Jamie Benson, our MLTC-approved delegate, participates in the six Board Meetings per contract year to provide thought leadership based on best practices and experience overseeing the integrated pharmacy benefit. For example, Ms. Benson led a DUR Board discussion regarding the Federal Drug Administration's approval of requiring that stimulants have an accompanying diagnosis for prescribing and dispensing. Additionally, we reported on our successful multi-prong educational intervention campaign to help MLTC meet the objectives of the opioid dosage taper strategy. We also educate our providers on the requirement to

[1] "Prescription Painkillers. After the Pain, They're Just Killers." Dose of Reality - Prevent Prescription Painkiller Abuse in Nebraska, https://doseofreality.nebraska.gov/.

check prescription drug history through the State's PDMP.

How DUR Results Will be Used to Inform MTM Education and Outreach

We integrate our DUR and Medication Therapy Management (MTM) programs to better identify members at risk of experiencing potential drug therapy problems, such as side effects and adverse interactions. DUR results inform our approach to engaging, educating, and outreaching members, physicians, and pharmacists in population health-based interventions. Based on a review of DUR data, our Pharmacy Team identifies areas of risk and uses the findings to develop criteria for MTM inclusion. In addition, we use DUR data to implement MTM Targeted Intervention Programs (TIPs). For example, when we saw DUR gaps in care for children on antipsychotics, we implemented a custom TIP: Needs Patient Education – First-Line Psychosocial Care for Children on Antipsychotics. When we noticed gaps in care for members with COPD and asthma, we implemented a custom TIP: Needs Drug Therapy – Rescue Therapy (COPD or Asthma). Certain DUR projects may include recommendations for outreach by our MTM vendors outside of their standard medication review processes. For example, we may identify opportunities for more appropriate drug therapy based on a DUR on a therapeutic class or disease state.

88. Describe the Bidder's proposed psychotropic drug oversight program to ensure appropriate utilization, including a description of the inclusion criteria that the Bidder proposes to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of:
• Tools to monitor and measure psychotropic prescribing patterns and usage.
• Processes to actively engage retail pharmacies and pharmacists in the oversight program.
• Plans for prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member.
• Processes to ensure that psychotropic medications prescribed to children are being prescribed appropriately and for the indicated diagnosis.
Page Limit: 4

Psychotropic Drug Oversight Program to Ensure Appropriate Utilization

Excelling in Person-Centered Care

Nebraska Total Care's Behavioral Health Medication Management (BHMM) program has provided rigorous, comprehensive psychotropic drug oversight of members' medication regimens for the past five years. BHMM ensures that psychotropic medication is clinically indicated and mitigates the risk of adverse drug reactions or health conditions. The success of the psychotropic oversight program to ensure the well-being of all Nebraska Medicaid members, not only Nebraska Total Care members, is a shared responsibility. Our five-year record of collaborating with MLTC and other health plans includes:

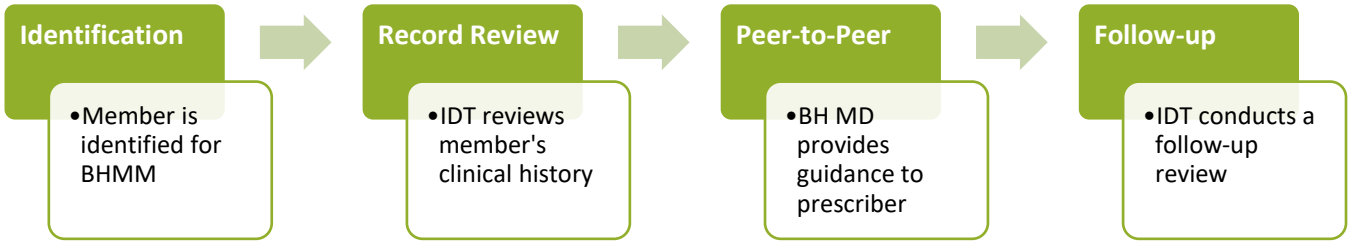
- Delivering a presentation, Foster Care Behavioral Health Polypharmacy, to the Department of Health and Human Services, the Division of Children and Family Services, and MLTC covering the issue of polypharmacy in foster care children taking psychotropic medications
- Supporting MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCPs and other network providers, including behavioral health providers
- Participating in interventions approved by MLTC
- Actively participating in DUR Review Board Meetings, providing thought leadership and solutions to comply with SUPPORT Act requirements, and recommending policy changes to ensure the integrity of the pharmacy benefit

46% Decrease

In 2021, our BHMM program delivered a 46% decrease in the number of medications and a 23% decrease in average per member per month spend post intervention.

BHMM's Inter-Disciplinary Approach. As described in **Figure 88**, An interdisciplinary team (IDT) of board-certified Nebraska-licensed child and adolescent psychiatrists, Master's level licensed behavioral health (BH) clinicians, clinical pharmacists, and Care Managers work together to ensure prescribers act within clinical practice guidelines set forth by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. The IDT identifies members receiving psychotropic medications using data from initial health risk screenings and assessments and monthly pharmacy claims reports. The IDT then conducts medication reviews of identified members using medical, pharmacy, and other clinical histories, not just prescription claims, to ensure members are on the appropriate medications and receiving BH support as needed. The IDT prepares member-specific profiles, including age subsets, of medication use based on pharmacy data to guide our interventions with prescribers. ***In 2021, we conducted more than 1,000 medication reviews through BHMM. One-third of the reviews resulted in Peer-to-Peer consultations with the member's prescriber.***
Monitoring For Metabolic Syndrome. The IDT engages the member's care manager to facilitate appropriate screenings and interventions for members on antipsychotics who are overweight or have abnormal glucose and lipid screenings. We educate providers about the need for regular lab work and monitor claims to ensure that labs are completed. When indicated, BHMM conducts metabolic monitoring and lab reviews to identify members who may be experiencing Metabolic Syndrome. ***In 2021, BHMM provided metabolic monitoring and lab reviews for over 1,400 members, resulting in 40% of members obtaining the recommended lab work within six months of the intervention.***

Figure 88 BHMM, our proposed psychotropic monitoring program, helps keep Nebraska's children safe and healthy.



BHMM Inclusion Criteria. We adopt the most current inclusion criteria from recognized experts, including through collaboration with the Drug Utilization Board, MLTC, Division of Behavioral Health, Division of Children and Family Services, Office of Juvenile Services, and the Nebraska Psychotropic Medication Committee. Our Behavioral Health Medical Director (BH MD) participates in interagency workgroups to ensure the program's inclusion criteria consistently meet the needs of Nebraskans. Presently members that meet any of the following criteria are listed in **Table 88.A Inclusion Criteria** may be referred to as BHMM.

Table 88.A Inclusion Criteria

Reason	Criteria
Insufficient Diagnosis	Absence of a thorough assessment for DSM-5 diagnosis in the medical record
Prescribing Outside Clinical Guidelines	Psychotropic medication dose exceeds usual recommended doses or is not consistent with appropriate care for diagnosed medical disorder or with documented targeted symptoms and therapeutic response
Prescribing Outside Scope of Practice	Prescribing by a Primary Care Provider who has no documented specialty training (unless recommended by a psychiatrist consultant) for a diagnosis other than Attention Deficit Disorder or uncomplicated anxiety disorders or depression
Metabolic Monitoring: Gap in Care	Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months
Polypharmacy	Potential class polypharmacy is defined by: • Two or more psychotropic medications for a given mental disorder before trying psychotropic monotherapy • Concomitant use within the same drug class of two or more stimulants, alpha agonists, antidepressants, and/or antipsychotic medications • Three or more concomitant mood stabilizers, and/or four or more concomitant psychotropic medications in youth, or five or more concomitant psychotropic medications in adults • Two or more sedative-hypnotics, or one side effect and one sedative-hypnotic, or two or more side effects from psychotropic medications in adults

Tools to Monitor and Measure Psychotropic Prescribing Patterns and Usage

We monitor and measure psychotropic prescribing patterns and usage through data-driven reports, retrospective drug data analyses, and even our Quality Improvement team as outlined in **Table 88.B Tools Measuring Psychotropic Prescribing and Usage**.

Table 88.B Tools Measuring Psychotropic Prescribing and Usage.

Tools	Description
BHMM Monthly Summary Report	This report captures the overall findings of BHMRs to identify prescribing patterns outside the parameters.
Quarterly Psychotropic Medications for Youth Report	This report identifies the number of psychotropic claims for children, adolescents, and foster care members submitted and paid, and the number of psychotropic claims submitted and paid outside age and dosing limits for ADHD drugs, antidepressants, antipsychotics, hydroxyzine, mood stabilizers, naltrexone, and sedatives.
Retrospective Pharmacy Reviews	Through retrospective DUR, we identify prescribing patterns such as narcotic and ADHD prescribing by the provider, dispensing rates by pharmacy, generic utilization rates, PA volume and denials, and 72-hour emergency supply dispensing rates. The review includes member utilization of psychotropic drugs, including medication adherence reports for Antipsychotics, SSRIs & SNRIs, and Anti-Manic Medications.
QI Performance Monitoring	Our Quality and Performance Improvement team conducts special reviews to detect unusual or inappropriate patterns of selected drug/pharmaceutical agents, such as inappropriate controlled substance prescribing patterns.

Processes to Engage Retail Pharmacies and Pharmacists in Oversight

Retail pharmacists play an essential role in psychotropic medication oversight. Below are examples of our approaches to actively engage retail pharmacies in the oversight program.

- **Nebraska Enhanced Services Pharmacies (NESP)**. We contract with a network of 61 clinically integrated pharmacies that develop, implement, and receive reimbursement for enhanced patient care services, such as medication management. The contract incentivizes these pharmacies to provide oversight over member psychotropic utilization.
- **Staff/Education Support**. Our Pharmacy Director, pharmacy staff (including Pharmacy Coordinators), network staff, Member Service Representatives, Medical Directors, and Care Management and Disease Management (DM) staff support pharmacists in medication oversight. Our oversight engagement begins at the point of contracting and continues throughout with Pharmacy Coordinators educating prescribers and pharmacists regarding pharmacy benefits, processes, and member utilization, supplemented by a continuous education program informing them of medication issues, trends, and PDL and PA changes.
- **Prospective Pharmacy Reviews.** Our Care Managers prospectively engage and educate providers on conditions of coverage and processes to promote patient safety. They also seek prescribers' treatment advice when developing service plans and update them on members' conditions, such as drug therapy issues or barriers.
- **Point of Sale Messaging**. The point of sale electronic claims system alerts and engages pharmacists with a Dangerous Drug Combination message such as opioid + benzodiazepine, an opioid and antipsychotic, or two central nervous system depressants. The system engages pharmacists by requiring a clinical evaluation that includes submitting professional evaluation codes acknowledging the combination to override soft edits.

Prescriber and Pharmacy Interventions

We take a partnership approach to interventions and thus lead with open communication, collaboration, and peer support. We describe the intervention process below from start to finish that has proved successful in reducing unsupported prescribing and reducing polypharmacy illustrated by ***a 46% decrease in 2021 in the number of medications 6 months post-intervention for members who received BHMR prescriber intervention.***

Provider Engagement. BHMM clinicians send Behavioral Health Service Review notices to providers to alert them to gaps in care or possible inappropriate prescribing practices, allowing the prescriber the opportunity to respond to and resolve the issue. If a provider does not respond to the notice or the information submitted by the provider is not sufficient to resolve the issue, the BHMM team requests medical records, such as lab results and provider notes from previous visits, to conduct an in-depth medication review.

Peer-To-Peer Consults. When the member's prescription drug regimen falls outside of the criteria and is not supported by medical histories, a BH MD contacts the provider and explains the purpose of the review and psychotropic medication prescribing standards. Our BH MD collaboratively formulates a treatment plan with the provider, documents the plan in TruCare Cloud, our collaborative Care Management and Utilization Management platform, and sends copies of the treatment plan to the provider and member's caseworker and/or juvenile probation/parole officer.

Follow-Up. The team clinician monitors the member's drug claims and discontinues provider monitoring when there is documented evidence that the treatment plan developed in collaboration with our BH MD is successfully followed, for example, when claims show a medication has been discontinued. For providers not adhering to the agreed-upon treatment plan, the BH MD engages them again. We refer providers whose prescribing practices remain unchanged to the Credentialing Committee for a corrective action plan.

Processes to Ensure Safe Prescribing for Children

Our BHMM program is intended to provide the right medication, at the right time, in the right dosage, for the right diagnosis, to ensure children receive the most appropriate, effective treatment. In addition to the inclusion criteria cited above, children under the age of 3 and receiving a stimulant; under the age of 4 and receiving an alpha agonist, antidepressant, or mood stabilizer; and/or under the age of 5 and receiving an antipsychotic are eligible for a BHMM. Our oversight processes to ensure the appropriate prescribing of psychotropic medications for children include:

- **Point of sale edits** alerting pharmacists to the PA requirements for psychotropic medications triggering a review by a Nebraska-licensed child and adolescent psychiatrist
- **The Foster Care Psychotropic Claim Report** identifying whether psychotropics processed for foster care members were within the age and quantity safety edits
- **Retrospective analyses** to identify top psychotropic drug prescribers and outlying prescribing patterns, and verify adherence to clinical policy recommendations
- **Peer-to-Peer consults** to educate providers on appropriate psychotropic utilization for children
- **Integrated Care Management** teams that include BH Care Managers to ensure the development of a comprehensive

and integrated plan of care that emphasizes coordination with BH services and other non-pharmacy services

- **Quality improvement methodology** to establish process and outcome measures for tracking data, trending data, and conducting quantitative and quantitative analyses
- MTM TIP at pharmacy point of sale for children on antipsychotics, Needs Patient Education – First-Line Psychosocial Care for Children on Antipsychotics

89. Describe the Bidder's methodology to evaluate disparities in medical management among races and ethnic groups and the correction of those disparities.

Page Limit: 2

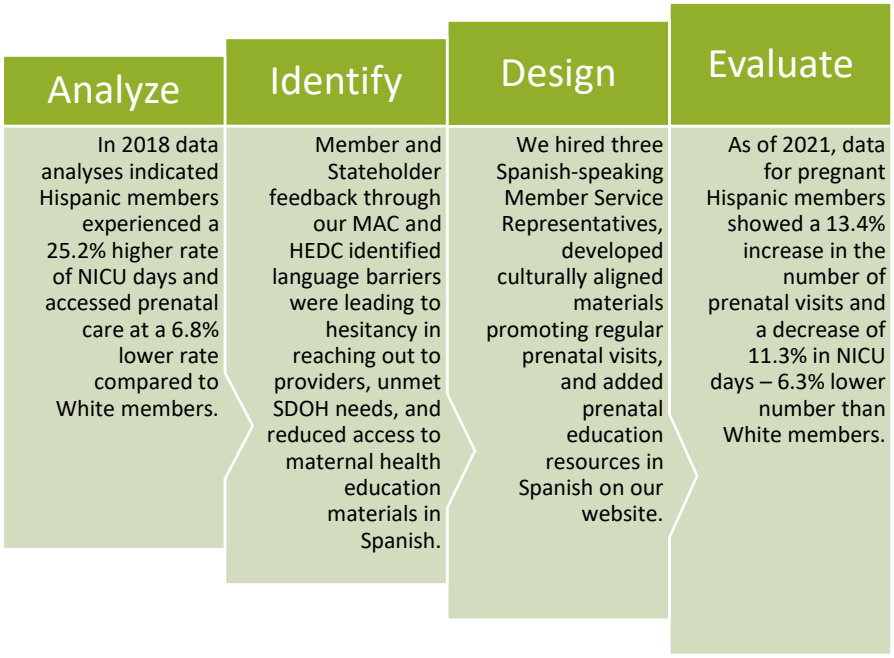
Identifying Disparities in Medical Management

Nebraska Total Care, in coordination with our parent corporation Centene, advances health equity through our evidence-based, ***Health Equity Improvement Model***, illustrated in **Figure 89.A**.

Figure 89.A A 2021 NCQA Innovation Award winner, our data-driven process identifies racial and ethnic health disparities and so we can develop, implement, and evaluate interventions to achieve health equity.

To identify disparities, we analyze multiple data sources, including HEDIS, CAHPS, assessments, grievances and appeals, Performance Improvement Project data, surveys, and input from members, providers, and stakeholders. We stratify HEDIS data by race, ethnicity, and language using logistic regression models. For members for whom we do not have this information, we use data-driven technologies to reliably attribute race and ethnicity based on local demographics. This enables us to accurately identify disparities within subpopulations using high-validity race/ethnicity data for 100% of our membership.

Figure 89.B An example of our Health Equity Improvement Model in action.



We developed a proprietary ***Health Equity Dashboard*** to identify disparity reduction opportunities and track related performance. The Dashboard displays our performance across 15 HEDIS measures by racial and ethnic groups using geomaps, tables, and bar charts, allowing us to easily recognize health disparities by race, ethnicity, and change over time (screenshot provided in response to Question V.T.111). The Dashboard's geomaps overlay SDOH data from our proprietary Neighborhood, Economic, and Social Traits (NEST) Tool, which analyzes over 200 data points to predict the risk of adverse health outcomes due to social factors. Under the direction of our Medical Directors, our Utilization Management team coordinates with other departments to develop meaningful solutions to improve health equity. Our Data Analytics team produces daily, weekly, monthly, quarterly, and annual reports for easy monitoring and trending against benchmarks over time.

Correcting Disparities

Health Equity and Diversity Committee. Our Health Equity and Diversity Committee (HEDC) is comprised of representatives from across our organization, including Behavioral Health, quality improvement, population health, network, pharmacy, and community outreach and includes staff with public health, epidemiology, and statistical expertise. The HEDC makes

recommendations for actions to eliminate disparities in health care, develops work plans, and evaluates our progress. We actively seek input from members across the State regarding their experiences accessing health care by including community representatives from diverse racial, ethnic, and geographic backgrounds, members with disabilities, and members who are dually eligible for Medicare and Medicaid. The diverse members and community organization representatives on our Member Advisory Committees inform and advise us on race and ethnicity issues, SDOH needs, and potential solutions. Our Care Management team partners with community–based organizations to understand and meet the needs of members. As our providers are an important source of information, we gather input via the Provider Advisory Committee, regular JOCs, Performance Improvement Team, QAPIC, and our Board of Directors. We use data analysis and stakeholder input to design member, provider, and community initiatives to address health disparities. Our model incorporates cultural sensitivity and awareness into care delivery to members, their families, and the communities.

Ensuring Access to Culturally Competent Care. Maria, a Spanish-speaking member, was experiencing a high-risk pregnancy. Marie utilized Nebraska Total Care's interpreter services to keep in close contact with her Care Manager, Jodi. As Maria was nearing the end of her pregnancy, Jodi contacted Maria to check on her progress. Maria informed Jodi she had been leaking fluid for four days but had not reached out to her doctor because as a Spanish-speaker, she had difficulties communicating with him. Jodi immediately arranged an appointment for Maria and upon examination it was detected that her amniotic sac had broken. Maria was taken directly to the hospital and within an hour she delivered a healthy baby. Because Maria was able to easily communicate with Jodi and share these details, a life-threatening situation was avoided. Maria says, "It was a blessing she called me that day." Maria shared her story in Spanish on YouTube, which was then shared by the Mexican Consulate in Omaha. The video has since been viewed over 3,800 times, demonstrating the impact Maria's experience has had within her community.

Tools to Support Primary Care Providers. We use our Health Equity Dashboard to evaluate member needs and care gaps by provider group and initiate targeted support when we identify disparities. To ensure PCPs deliver culturally appropriate care, we provide comprehensive, tailored training on the unique demographic factors that contribute to community-wide health concerns and how these barriers can be overcome. Training includes Poverty Competency; Cultural Competence; Guidelines for Working with Native American Population; LGBTQAI+ education; SDOH Training. We provide access to external training such as Tribal Education and CLAS in Maternal Health Care. PCPs can look to the ***Findhelp Community Resource Platform*** to connect members to community-based resources. Our provider incentive programs and Value-Based Purchasing strategies incentivize providers to engage hard-to-reach and underserved populations and ensure access to prevention, primary care, and appropriate treatment. We educate providers on the use of z codes, which helps us evaluate SDOH needs at the member and community levels.

Health Equity Neighborhoods. Building on the community-anchored, collaborative aspects of our Health Equity Improvement Model, we will design and implement new Health Equity Neighborhoods in high-needs cities and zip codes across Nebraska. Health Equity Neighborhoods are a Centene-developed national best practice for identifying and addressing disparities through hyper-focused community-wide engagement, based on data from the Robert Wood Johnson Foundation and other public health models. We start by engaging established, anchor community entities, such as local United Way and Urban League chapters, to conduct health equity formative research on local lived experiences and needs. Engaging with local stakeholders from across the target area, we partner on SDOH interventions and funding. ***In each Neighborhood, Nebraska Total Care and our anchor partner will convene community-based organizations (CBOs) and residents, physical and behavioral health providers, local government agencies, and other stakeholders to develop Neighborhood Councils charged with developing a collaborative HE Neighborhood action plan.*** The action plan identifies resources and services to develop – or in some cases, identifies existing programs to invest in and expand – as part of a coordinated set of health equity interventions.

Using the data and tools described, we identified three Neighborhoods that consist of counties and zip codes with the greatest disparities and SDOH needs for an initial pilot. The three HE Neighborhoods are comprised of two specific zip codes in Omaha (68111 and 68104) and one zip code in Scottsbluff (69361). Although we are implementing the HE Neighborhoods in just three communities initially, our goal is to scale this innovative initiative across Nebraska based on findings and lessons learned from the initial pilot and feedback from local stakeholders. Our Health Equity Neighborhood initiative is described in detail in response to Question 114.

RFP 112209 O3

Attachment B.82
PA List

Attachment B.82 PA List

Ancillary Services	
• Cochlear implant • Durable medical equipment (includes enteral and parenteral pumps, wound vacs, bone growth stimulator, customized equipment) • Fixed wing non-emergency air transport • Hearing aid devices • Home health care (includes infusions, home health aide, private duty nursing) • Hospice services (other than inpatient facility)	• Hyperbaric oxygen treatment (outpatient) • Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular or penile prosthesis, vagus nerve stimulator) • Orthotics and prosthetics • Rehabilitative therapies (including occupational, physical, speech therapies)
Behavioral Health	
• Autism spectrum disorders, diagnosis, and treatment and habilitative services • Psychological and neuropsychological testing administration and scoring • In-home psychiatric nursing • Multi-systemic therapy (PA required after 244 lifetime units) • Assertive Community Treatment program • Community Treatment Aide (PA required after 144 lifetime units) • Partial hospitalization • Electroconvulsive therapy • Day treatment • Intensive outpatient • Community support services • Day rehabilitation services • Secure residential rehabilitation services • Residential services	• Therapeutic group home • Day treatment (PA required after 144 lifetime units) • Psychiatric residential treatment facility • Crisis intervention mental health services (PA required after 3 units) • Risk assessment for youth for sexual harm • Social detoxification • Dual-disorder residential • Short-term residential • Intermediate residential • Therapeutic community • Halfway house • Medically monitored residential withdrawal management • Inpatient (requires notification within 1 business day of admission) • Sub-acute inpatient psychiatric hospitalization
Facility Services: (includes medical, behavioral health & substance use)	
• Elective/planned hospitalizations • Emergency admissions and/or observation (requires notification within 1 business day of admission) • Observation services (outpatient)	
Pharmaceuticals	
• Enteral/parenteral formulas • Selected injectable therapy/biopharmaceuticals (Synagis, growth hormone, Sovaldi, interferon) • Specialty pharmaceuticals	
Physician Office Services/Procedures	
• Infertility treatment • Pain management services • Plastic surgery/potentially cosmetic • Transplant related services (evaluation, testing)	
Radiology & Laboratory Services	
• CT, MRI, MRA, nuclear cardiology, nuclear radiology, PET scans • Genetic/molecular diagnostic testing • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid	

- OB ultrasounds (PA required after 2 ultrasounds, except when rendered by a Perinatologist)
- Quantitative drug screening

Surgery & Procedures

- Ablative techniques for treating Barrett's Esophagus and primary and metastatic liver malignancies
- ALCAT allergy testing
- Bariatric surgery
- Capsule endoscopy
- Cardiomyoplasty
- General anesthesia for dental procedures
- Hyperhidrosis treatment
- Joint replacement
- Lung volume reduction surgery
- Maze procedure (for treatment of atrial fibrillation)
- Muscle flap procedure
- Orthognathic surgery (for treatment of maxillofacial [jaw] functional impairment)
- Pain management services
- Potentially cosmetic or plastic surgery (blepharoplasty, blepharoptosis repair, cranial/facial/jaw procedures, nasal/sinus surgery, and vein procedures)
- Potentially experimental treatment/clinical trials
- Sleep apnea procedures and surgeries
- Sleep studies
- Spinal surgery
- Surgeries/procedures performed in outpatient facilities or ambulatory surgery centers
- Tonsillectomies in children
- Transplant surgery
- Ventriculostomy
- Wearable cardioverter-defibrillators

Dental Services

- Crowns
- Dentures
- Orthodontics
- Periodontal scaling and root planing and maintenance

(Only some CDT codes in the above categories apply)

Out-of-Network Providers & Services

Out-of-network providers and services – excluding emergency care and post-stabilization services

RFP 112209 O3

B. Technical Approach

V.O Program Integrity

V.O Program Integrity

90. Describe the Bidder's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the Bidder has utilized in other states.

Page Limit: 4

Nebraska Total Care's Program Integrity Approach

As an incumbent Managed Care Organization (MCO) serving Nebraskans since 2017, Nebraska Total Care remains committed to fostering ethical behavior and protecting Nebraska's tax dollars. We focus on compliance and the prevention, detection, reporting, and implementation of corrective actions for suspected cases of fraud, waste, and abuse (FWA) and erroneous payments. ***Since 2019, our total FWA and erroneous payment cost savings was over $47 million***. We apply a multi-prong Program Integrity approach including compliance, FWA, and payment integrity components. We draw upon national best practices leveraging the experience of our 29 Medicaid affiliates across the country and our relationships with State and Federal task forces on Medicaid FWA control.

Compliance Plan. Nebraska Total Care's Compliance Plan complies with the Scope of Work (SOW) including Section V.O – Program Integrity and Attachment 13 – Reporting Requirements, State and Federal Laws specifically 42 CFR § 438.608, and all policies of the Nebraska Division of Medicaid and Long Term Care (MLTC), Medicaid Fraud and Patient Abuse Unit (MFPAU), and Nebraska Medicaid Program Integrity Unit (NMPI). Our Compliance Plan, based on the OIG's seven elements of an effective compliance program, safeguards Medicaid funds against the unnecessary or inappropriate use of services and payments. Our FWA and payment integrity processes and best practices, described below, will achieve increased accountability, meaningful measurement, optimal resource efficiency, and sophisticated data oversight in the new 2023 MLTC Contract. Key Compliance Plan elements include:

- Ongoing monitoring, auditing, and oversight including Subcontractors
- Effective communication between stakeholders, including anonymous reporting options and confidentiality
- Whistleblower protection and anti-retaliation
- Enforcement, corrective action, disciplinary guidelines, and standards of conduct
- Policies and procedures for FWA and erroneous payment prevention, detection, investigation, and recovery
- Training and education of all employees including the Board of Directors

We report our Fraud, Waste, Abuse, and Erroneous Payments Annual Plan to MLTC and certify all claims, statements, and reports submitted for payment are true, accurate, complete, and eligible for submission and reimbursement. Nebraska Total Care demonstrates this commitment in our Annual Program Integrity Confirmation signed by our Contract Compliance Officer. We acknowledge our responsibilities related to the receipt of State and Federal funds including the compliance of all employees, providers, Subcontractors, and vendors.

Compliance Oversight and Training. Our full-time, Nebraska-based Program Integrity Officer reports directly to our Chief Executive Officer (CEO), oversees our compliance program, manages our Special Investigation Unit (SIU), serves as the primary point of contact communicating to MLTC on Program Integrity and serves dually as our Contract Compliance Officer (CCO). Our CCO leads our Compliance Committee, which functions as a regulatory compliance and oversight committee of cross-functional leaders and stakeholders who review key compliance practices, meet at least quarterly, and review ongoing progress and updates to our Compliance Plan. Our Program Integrity Officer reviews the status of FWA cases routinely, at quarterly Compliance Committee meetings and monthly SIU meetings for internal oversight, enforcement, and collaboration. To supplement assigned in-person and online training, our Compliance team(s) publishes a monthly "Compliance Corner" article, providing compliance education on a variety of timely topics in an email to all Nebraska Total Care employees and a post on our website.

Training and Education

Nebraska Total Care's training team conducts compliance training, and all employee's complete compliance education within 30 days of hire and annually thereafter. For example, our 2022 training schedule includes 12 mandatory compliance modules assigned throughout the year and covers topics including the Federal False Claims Act and whistleblower protection.

SIU Staff Training and Education. Mandatory SIU staff training, and education include 18 hours of National Health Care Anti-Fraud Association (NHCAA) webinar-based training and internal training that total at least 30 SIU training hours annually. Internal collaboration gives Nebraska Total Care a Program Integrity advantage. Monthly, SIU investigators and Nebraska Total Care business leaders, including representatives from Compliance, Population Health, Claims, Provider Services, and Finance, discuss trends, risks, opportunities, and forecasts that influence the Medicaid program.

Preventing, Detecting, Reporting and Correcting FWA. SIU investigators dedicated solely to Nebraska Total Care use their experience in health care claims review, data analysis, professional medical coding, and law enforcement to identify, review, recover, and report improper payments, including FWA activities. ***Since 2019, our SIU has recovered over $380,000 in improper payments.***

Our Program Integrity Officer leads our SIU team, which includes at least one Nebraska-based SIU full-time employee per 50,000 or fewer members whose primary responsibility is FWA. Our local SIU team leverages staff at our parent company, support from SIU staff at our health plan affiliates, and a full suite of information technology tools, dashboards, and reports.

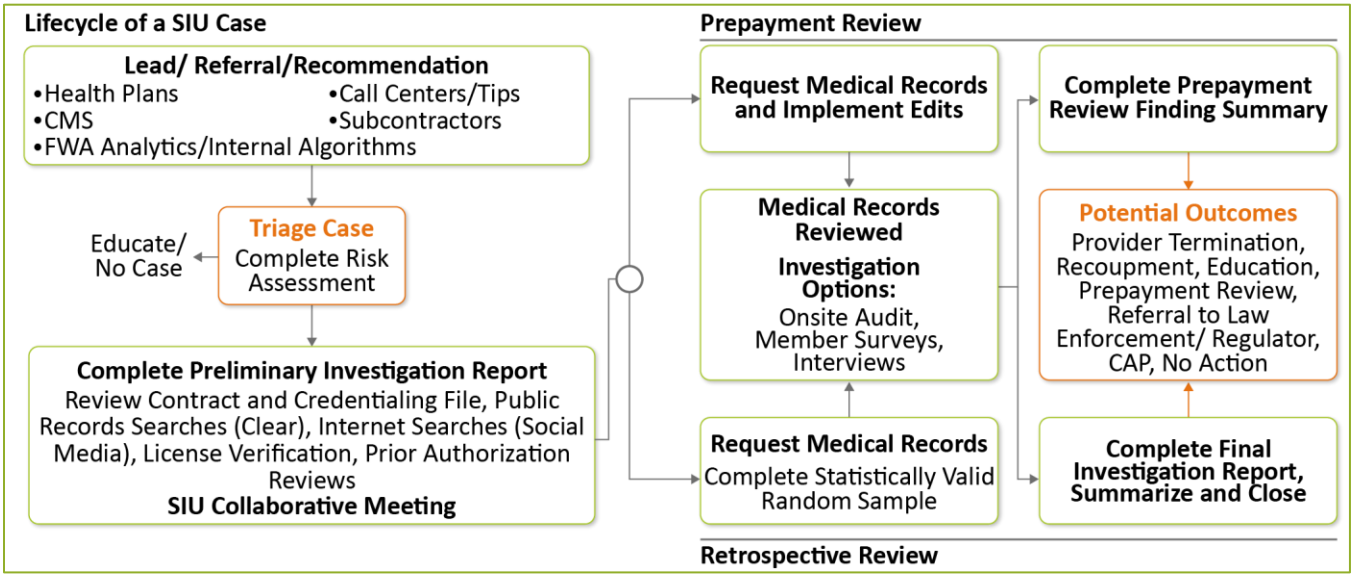
Preventing and Detecting FWA through Tips and Investigation. Nebraska Total Care encourages all employees, providers, Subcontractors, and members to take responsibility for upholding Program Integrity, including the identification and reporting of FWA. Sources of tips include our FWA compliance hotline and website submissions, MLTC, other MCOs, State/Federal agencies, members, providers, affiliates, and our parent company. **Table 90.A** depicts SIU processes and tools for effective investigations.

Table 90.A SIU Investigation Processes and Tools

Process and Tool	Description
Referrals	We encourage providers, Subcontractors, members, and employees to report any potential FWA cases. Our 24/7, confidential, toll-free FWA compliance hotline is published on our website. We commonly receive notifications of potential FWA during NMPI's regular Program Integrity meetings with other MCOs.
NHCAA SIRIS	As a member of the NHCAA, our parent company has access to SIRIS, the NHCAA information-sharing website that includes regular postings of information about potential provider FWA activities by more than 100 insurance companies nationwide. SIU investigators use SIRIS as part of the due diligence they perform in their investigations.
Investigation Software Options	SIU investigators use powerful online investigation software throughout different phases of a case lifecycle such as Thomson Reuters CLEAR which provides a vast collection of public and proprietary records to enable SIU investigators to uncover hard-to-find data from a large number of records and diverse sources, which are updated consistently with current information.

Our FWA policies and procedures guide our process for investigating, documenting, and resolving tips. In 2021, our SIU opened ***74 MLTC cases*** due to FWA concerns. **Figure 90.A** depicts the typical lifecycle of an SIU from tip to resolution.

Figure 90.A SIU Case Flow: Sources/Tips, Investigation, Resolution, and Reporting



Investigating Potential FWA. When we receive an allegation, tip, complaint, or referral of suspected fraud, our SIU files an immediate FWA report with NMPI to indicate we have initiated a potential FWA case. Our SIU promptly conducts a preliminary investigation to determine whether a credible allegation of fraud exists. In the preliminary investigation, the SIU may utilize a risk assessment tool or conduct a similar internal analysis to determine referral priority of high, medium, or low by scrutinizing the provider's financial exposure, member vulnerability, risk of reoccurrence, and regulatory violations. We classify risk to determine the next steps in the investigation, which may include provider education, escalating for

further review, or recommending closure of the case. Our SIU may request medical records to determine if potential fraud extends beyond what the referral or prepayment software identified. After the initial review, our SIU staff completes the preliminary report, which may include a recommendation to review additional medical records, conduct an onsite investigation, interview members, providers, or Subcontractors, educate, and/or recover overpayments.

Upon completion of the preliminary investigation and report, we seek permission to proceed from NMPI or MFPAU and cooperate in any State or Federal investigations providing information, records, data, access, and interviews in the required form and manner. Nebraska Total Care maintains appropriate confidentiality throughout the investigation process.

Reporting, Recovering, and Corrective Actions for FWA. We promptly proceed with provider payment suspension and a complete investigation when permitted to protect Medicaid funds and safeguard member care and experience. Our SIU files a completed investigation report and the following status reports to NMPI and MLTC according to SOW Section V.O.7 and Attachment 13 providing visibility of all preliminary, active, and completed investigations:

- Biweekly Tips Report
- Monthly FWA Abuse Interventions Report
- Monthly FWA Detection Effort Report
- Quarterly FWA trending Report

If a case warrants issuing a corrective action plan (CAP), the applicable Nebraska Total Care functional area initiates and manages the CAP. Based on the specific case, we impose a variety of corrective actions, including member or provider education, Federal/State referral, 100% prepayment review for a provider, and recovery of overpayments. We pursue the recovery of overpayments identified as FWA given NMPI permission, update the associated encounter records and reports, and complete overpayment reporting and return within 60 calendar days of identification following the eligibility criteria and process of Section V.O.2. Recovery of Overpayments.

Preventing, Detecting, Reporting and Correcting Erroneous Payments. While our SIU focuses on investigating potentially fraudulent and/or abusive providers and members, Nebraska Total Care's Payment Integrity department addresses wasteful provider billing spend, such as coding errors, COB recoveries, and overpayments. ***In combination, our prepayment and post-payment Payment Integrity efforts have saved Nebraska over $46.8 million since 2019.***

Preventing and Detecting Erroneous Payments Using Technology. Comprehensive prevention activities offer the most effective approach to erroneous payments, as they minimize the need for less efficient downstream overpayment recovery efforts tied to FWA. For this reason, Nebraska Total Care invests in upstream prevention strategies, such as provider and Subcontractor network integrity, prepayment claim edits, and FWA prevention and detection analytics. **Table 90.B** depicts our prepayment processes and technology.

Table 90.B Prospective Erroneous Payment Claims Edits and Reviews

Edit	Description
Primary Claim Editing Software	Nebraska Total Care uses Claims Xten™ (CXT), integrated with our claim system, as our primary claim code editing software. Following claim adjudication, we analyze all claims in real-time by CXT to determine clinical claims coding appropriateness and fraudulent billing practices. CXT reviews claims against common coding standards established by the American Medical Association (AMA), CMS, and medical specialty societies. CXT identifies potential FWA triggers such as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.
Secondary Claim Editing Software	We use secondary claim code editing software to compare submitted claims to correct coding rules/guidelines. The software reviews the claim and compares services to the member's history to determine if the service is medically likely. Edits are based on CMS, AMA/Current Procedural Terminology (CPT®), and Specialty Societies.
Third-Party Liability (TPL) / Cost Avoidance	We update the member "other insurance" fields in our Claims Processing System, allowing us to apply appropriate rules during adjudication for TPL cost avoidance to prevent waste. If our system pends or denies the claim based on information within the member's TPL record, we notify the provider of the reason for denial and the primary carrier's name and member eligibility dates.
Electronic Visit Verification (EVV)	We will use a common EVV vendor as specified in SOW Section V.Z for home health services to collect data, validate service types, and support claims adjudication.
Duplicate Claims Edits	Through machine learning models, we prevent waste by scanning for potential duplicate claim submissions by identifying claims with the same service dates, procedure codes, modifiers, diagnosis codes, provider identification numbers (such as National Provider Identifier and Tax ID), charged amounts, member information, and potential bundling/unbundling of services.
Clinical Reviews	Nebraska Total Care reviews for clinical appropriateness and publishes policies followed during the

Edit	Description
	claims payment process. The clinical review provides an additional screening of clinical billing discrepancies on a prepayment basis.

Correcting Retrospective Erroneous Payments Using Technology. We have a plan to detect erroneous payments tied to FWA after completion. Our retrospective approach uses the processes and tools of **Table 90.C**.

Table 90.C Retrospective Erroneous Payment Processes and Tools

Tool	Description
FWAShield™	FWAShield™ contains multiple tools (CaseShield™, PostShield™, QueryShield™, RxShield™) that detect FWA, electronically house SIU files and documents and link SIU cases to internal and external reference sources (including medical records).
CaseShield™	CaseShield's™ FWA case tracking and case and financial reporting capabilities align with the NHCAA, Nebraska, and Federal financial reporting standards.
PostShield™	PostShield™ contains powerful fraud rules and algorithms developed by industry experts who understand fraud detection and prevention. These post-payment algorithms produce smarter results and fewer false positives with unique external data sources incorporated into PostShield's analytics. SIU analysts use PostShield for potential leads.
QueryShield™	QueryShield™ is an ad-hoc querying tool that enables a user to run real-time queries and complex-pattern reports from data loaded into PostShield and CaseShield. QueryShield completes template reports, summary reports, trending reports, cross-claim queries, impact analysis, and customized reports to meet specific Nebraska reporting needs.
RxShield™	RxShield™ empowers users to monitor pharmacy expenditures. By conducting cross-claim analysis between pharmacy and medical claims, RxShield identifies prescription drugs improperly billed, detects prescribers providing medications inappropriate for diagnoses or outside the standard of care, and demonstrates abusive member prescription patterns.
Data Mining	Payment Integrity identifies overpayments using data mining processes, in-house solutions, and subcontractors reviewing paid claims data to ensure proper payments were made.
Artificial Intelligence (AI) Models	SIU analysts use AI Models to identify FWA while increasing savings, recoveries, and referrals. AI offers value over traditional rule-based fraud detection programs because it uses neural network learning to identify procedures inconsistent with a member's demographics, the reason for visiting a provider, and final diagnosis or providers billing codes more often than specialty peers.
Rules-Based Scenarios	These analytic tools based on clinical policies identify outliers such as provider billing.
Medical Record Audits	These audits on targeted inpatient paid claims to ensure the diagnosis-related group (DRG) and level of care coding on the claim billed is supported by the records.

National Program Integrity Best Practices. We incorporate feedback, collaboration, and best practices from our health plan affiliates in other states to enhance our Program Integrity effectiveness, and accountability in Nebraska.

Compliance Management System. We use the same proven Compliance Management System as our 29 health plan affiliates, which allows departments and delegates; tracks compliance activities; maintains auditable records of management approvals, contract requirements, and regulatory mandates; and allows for ongoing assessment of compliance Nebraska Total Care to effectively administer, monitor, and oversee internal policies and procedures as well as external contracts, regulatory guidance, and corrective action plans. This system provides workflow-enabled policy and procedure formulation with a complete history of documentation and sign-offs. Our Compliance Management System includes the capability to distribute documents to the appropriate Nebraska Total Care risks and security. ***We will load our finalized 2023 MLTC Contract into this tool for the compliance oversight, policy and procedure development, ongoing assessments, and updates.***

SIU Affiliate Collaboration. Nebraska Total Care's SIU investigators work collaboratively with their Medicaid health plan peers across the country, meeting regularly to share examples of successful cases, identify FWA schemes, and discuss investigation best practices. During monthly meetings, affiliate health plans present cases with favorable outcomes across other markets and states. Affiliate presenters outline their investigation, approach, key indicators, and tips. After the meetings, affiliate SIU teams share their resources for Nebraska Total Care investigators to leverage these successful methods in Nebraska. The lessons learned from working in concert with dozens of other SIU professionals continuously improve our Program Integrity skillset.

91. Describe how the Bidder currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the Bidder apply methods in Nebraska?

Page Limit: 2

Nebraska Total Care's FWA Collaboration with Other Entities

As an incumbent health plan, Nebraska Total Care builds relationships and works with other entities that investigate and prosecute fraud, waste, and abuse (FWA) for positive Program Integrity outcomes. We meet SOW Section V.C.5 requirements and cooperate fully with all FWA and erroneous payment oversight entities at the State and Federal levels, including the Nebraska Medicaid Program Integrity Unit (NMPI), Medicaid Fraud and Patient Abuse Unit (MFPAU), MLTC, DHHS, CMS, OIG, and other MCOs. At least one Nebraska-based FWA investigator attends the Nebraska Health Care Fraud Taskforce meetings when scheduled. Our Program Integrity Officer and Nebraska-based SIU investigators attend NMPI's regular meetings with all MCOs to review and discuss investigations, compliance, prevention, and other Program Integrity topics. We actively participate in MLTC and MFPAU FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members.

Supporting MLTC Programs and Planning Initiatives. Our FWA collaboration activities support the MLTC goals of establishing and enhancing beneficial relationships with the Nebraska community, stakeholders, and policymakers. To guide these activities, we maintain policies and procedures, designate points of contact, and establish leadership oversight. We review our Compliance, FWA, and payment policies and procedures at least annually and make enhancements based on MLTC programs and planning initiatives. For example, we support MLTC's System Transformation Initiative by continuously improving Program Integrity data exchange, monitoring analytics, and providing transparent customizable reports to stakeholders. Nebraska Total Care participates in CyncHealth with other health care providers, payers, and the State to reduce administrative burden and act on Program Integrity results such as member eligibility, emergency department utilization, and prescription drug monitoring. Nebraska Total Care will work with other awarded MCOs to procure and collectively contract with a common Electronic Visit Verification (EVV) vendor/solution provider for Home Health Care Services according to SOW Section V.Z. After successfully implementing a single EVV vendor/solution provider, we will review EVV information to monitor for potential FWA, ensuring the services reimbursed were rendered and utilized appropriately.

Collaborating with MLTC to Stop FWA

Our SIU opened a case from a referral for possible upcoding and found the provider almost exclusively billed the highest level of psychotherapy. We requested medical records for clinical review which supported the upcoding allegation, an overpayment of $47,549, and identified other areas of concern. Our SIU referred the FWA to NMPI and placed the provider on 100% prepayment review. MFPAU now owns the case. This collaboration resulted in $80,000 in prepayment savings, and the provider's billing dramatically decreased. As a result, we opened cases on affiliated providers, identified overpayments of $20,923, achieved $14,974 in prepayment savings, and sent an additional FWA referral to NMPI.

CMS Audit Participation. Nebraska Total Care participated in a CMS Program Integrity review in early 2022. We attended meetings with CMS auditors and provided documentation on our internal FWA prevention, detection, and correction efforts. The collaborative review allowed us to share our approach to FWA and erroneous payments with CMS staff and details on our collaboration with MLTC Program Integrity staff. Nebraska Total Care met expectations in the oral interview with CMS auditors and will incorporate enhancements into our Program Integrity program as CMS provides any follow-ups.

Ensuring Proper Provider Eligibility and Credentialing. Our Program Integrity commitment includes an ongoing obligation to verify provider credentials and enrollment, exclude ineligible providers from contracts and suspend payments, and report ineligible providers to MLTC and NMPI. We monitor OIG exclusions monthly for provider list validation and maintain policies and procedures to submit a provider file to MLTC, immediately notify NMPI of terminated providers or providers leaving our network and send a Monthly Provider Network Changes Report.

Nebraska Total Care in collaboration with other MLTC MCOs will procure a common provider credentialing service within one year of the 2023 Contract start date according to the requirements of SOW Section V.I.16. We will use a Central Credentialing Verification Service (CCVS) to achieve:

- Consistency in provider eligibility, screening, and credentialing
- Accuracy in Provider Directories across MCOs
- Simplicity in administration and contracting
- Efficiency in network management and Care Coordination

Vetted, reliable, and transparent provider data increases our ability to coordinate and integrate care for members across network providers and covered service types.

Collaborating with Subcontractors. Our SIU works collaboratively with Subcontractor entities to ensure proper benefit utilization. Our Subcontractors for pharmacy, dental, and vision actively mine data for suspicious billing patterns, appropriate utilization, prior authorization procedures, record-keeping practices, and accurate diagnosis routines. Upon discovering potential FWA, our Subcontractors collaborate with the Nebraska Total Care SIU to finalize investigative next steps. We refer cases to NMPI and MFPAU and cooperate in State or Federal regulatory agency investigations. Our SIU may analyze audit findings, pursue investigations on suspicious activities of members and/or providers, and address concerns with the Subcontractor for additional investigation. We track all referrals sent to and from Subcontractors for investigation, monitoring, and reporting. **Table 91.A** depicts recent cases resolved collaboratively between our Subcontractor, Envolve Dental, and affiliate health plans SIU staff.

Table 91.A Collaboration in Affiliate Dental FWA Cases

Affiliate	Dental FWA Case and Outcome
Mississippi	The dental provider was identified as an outlier for billing sealants. An investigation determined the provider placed sealants on healthy and unhealthy teeth, meaning sealants were inappropriately placed on teeth needing restoration due to cavities. ***SIU recovered $5,700 and educated the provider.***
Indiana	Dental providers were identified as an outlier for billing an excessive number of crowns on pediatric patients. The investigation determined the provider failed to restore many of the children's teeth with more conservative measures. ***SIU recovered $24,700 in IN and educated the providers.***
Illinois	Dental providers were identified as billing excessive services for pediatric patients. The investigation determined the provider failed to restore many of the children's teeth with more conservative measures and staged care to maximize revenue per child by performing restorative procedures on non-restorative teeth before ultimately placing crowns. ***SIU recovered $1,500 and educated the provider.***

Partnering with National Vendors for FWA. Nebraska Total Care works with a national vendor to conduct prepayment reviews of high dollar inpatient itemized bills to identify unbundled charges, non-covered charges, and billing errors. Providers receive an itemized bill review report that outlines and explains the allowed outlier payment reimbursement. This process ensures we pay for appropriate charges, eliminate waste, and protect Medicaid funds, while providers retain their appeal rights. ***In 2020 and 2021, 100 prepayment reviews resulted in over $2.4 million in total net savings.***

Nebraska Total Care also works with Cotiviti to conduct a monthly audit of inpatient claims paid using Diagnosis Related Group (DRG) Validation. Cotiviti identifies claims paid via DRG reimbursement, requests records from the provider, and reviews documentation to determine if clinical records support the DRG billed and reimbursed. When record review supports reimbursement as billed, we uphold payment and no further action occurs. When record review does not support the DRG billed, we notify providers of claim recovery and adjustment for reimbursement at a level supported by the documentation. Providers retain appeal rights. ***Since 2019, our DRG efforts resulted in over $6.7 million in savings.***

Nebraska Total Care works with Performant to conduct monthly post-payment audits of Home Health and Durable Medical Equipment (DME) claims to support appropriate billing and reimbursement. Performant identifies DME/Home Health claims for post-payment review. We send providers with a claim selected for post-payment audit a written notice of the audit and request medical records to substantiate services. Performant completes a documentation review. If the records support the service billed, the provider retains payment as billed and reimbursed. If Performant identifies an unsubstantiated service record, we notify the provider of payment recovery. Providers retain appeal rights. ***Since its launch in June 2021, Nebraska Total Care's DME/Home Health post-payment review process saved nearly $331,000.***

Applying Our Proven FWA Methods in Nebraska. Nebraska Total Care will continue to invest in the prevention, detection, reporting, and correction of FWA and erroneous payments based on our current work with other entities and Nebraska's experience in the past five years. We consider the top risk areas for the Medicaid program, contractual requirements, MLTC goals, lessons learned from external investigations, and guidance offered by subject matter experts at the State and Federal levels to be Program Integrity objectives, priorities, and investment opportunities. Areas of focus based on risk, return, and trends include:

- BH, chiropractic, and telehealth services
- Billing for services not rendered
- False or unnecessary issuance of prescription drugs
- Overutilization of services
- Billing for a non-covered service as a covered service
- Upcoding and unbundling
- Misrepresenting date, location, or provider
- Incorrect diagnosis/procedure reporting

92. Currently, how does the Bidder educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the Bidder apply methods in Nebraska?
Page Limit: 3

Program Integrity Education Methods

Our fraud, waste, and abuse (FWA) and erroneous payment education program for members and providers support MLTC's goals of administrative simplification, efficiency, and consistent accountability for the proper use of Medicaid funds across Nebraska Total Care, our network providers, and the members we serve. We equip members and providers with resources and support to develop their behaviors, skills, and competencies in FWA prevention. Ongoing education includes providing notice at least 45 calendar days before Program Integrity-related policy changes, training opportunities, accessible guides to support understanding, and an educational corrective action process used in compliance enforcement.

Educating Members to Prevent FWA and Erroneous Payments. Our Program Integrity Member Education Plan includes all the requirements of SOW Section V. F Member Services and Education. We educate members about FWA prevention through the Member Handbook, Quarterly Member Newsletters, Member Portal, and the Nebraska Total Care website. We provide these resources to all new members, including those who lose eligibility and re-enroll. Our materials guide members about the proper use of the Emergency Department (ED), utilization issues, examples of FWA, and guidance to report suspected fraud or abuse.

Examples of our member FWA educational topics include:

- When do I visit my Primary Care Provider (PCP), and when should I go to the ED?
- What should I do if my member ID card is lost or stolen?
- How do I call or email to report FWA?
- Why did I receive an Explanation of Benefits (EOB), and how do I read it?
- What should I do if my EOB is not correct?

Member Services Staff Support for Members. Nebraska Total Care supports ongoing Program Integrity education for members with key staff and resources. Staff includes Member Service Representatives (MSRs), Care Managers, our Member Services Call Center, and the FWA compliance hotline, who communicate with members verbally and in writing. For example, ED utilization data may identify patterns of inappropriate overutilization of the ED by certain members, which constitutes waste. A Care Manager will contact each member to determine why the member is utilizing the ED. If appropriate, the member may enroll in a Care Management or disease management program to assist them in better managing their condition. Our MSRs provide members information on how to report suspected FWA and help them make a report if needed.

Training the Trainer

To provide effective education to members and providers on FWA, Nebraska Total Care starts with competent trainers. Our member and provider FWA training team consists of Member and Provider Service Representatives (MSRs/PSRs), Care Managers, our Provider Claims Educator, and our Provider Network Liaison. These FWA training staff receive communication and resources (such as quick reference desk flyers) from our Program Integrity Officer, Compliance Committee, and their respective departments to support ongoing FWA education and understanding of new processes and trends.

Print Resources for Members. Resources include our new member Welcome Packet, sent to members in the first 10 days of enrollment, that introduces members to FWA and erroneous payment prevention. The Welcome Packet contains details to access our Member Handbook that functions as an ongoing FWA reference for the member. Digital member resources include the Nebraska Total Care website and access to our Member Portal. These resources prominently display our toll-free FWA compliance hotline and explain its function and importance. FWA is reinforced during the new member welcome call, which is conducted within 10 days of the Welcome Packet being sent.

In addition to fraud reporting instructions via phone and email options for members, our Member Handbook educates members about Program Integrity topics. Members may access the Handbook online or request a paper copy in the mail per our Welcome Packet instructions. Members learn how to self-report changes in status such as family size, mailing address, living arrangement, income, other health insurance, assets, or other situations that might affect ongoing eligibility. The Handbook describes appropriate and inappropriate behavior when seeing a provider and using their member identification (ID) card. Members understand they are responsible for protecting their ID card, what constitutes a misuse of the card including loaning their ID to another person, and the associated consequences including loss of eligibility or legal action.

The Member Handbook also describes the EOB that Nebraska Total Care conducts within 45 days of a claim payment according to the requirements of SOW V.S.7 Paid Claims Sampling. Members learn it provides a written statement of what services they received, from which provider, on what date, and does not constitute a bill. Rather, the EOB conveys to the

member the benefits they received and allows them to report any suspected FWA if the EOB services do not match their appointment or services as rendered. Members who receive an EOB but believe they have not received a service are instructed to call our Member Services department, which then refers the information to our SIU for follow-up.

Digital Resources for Members.

- The secure Member Portal provides a variety of resources for members. Via the portal members can access their digital EOB for services and view their claims history. Members may submit compliance questions via our secure messaging feature and receive a Nebraska Total Care response. Additionally, the Member Portal links to resources such as our Find-a-Provider tool as well as the most recent Member Handbook.
- The website allows members to review the FWA resources discussed above in digital form for quick searches, easy navigation, and bookmarking capability. The website contains the electronic version of our most recent Member Handbook and archives Member Newsletters. It also contains a variety of resources including the FWA compliance hotline number, and compliance inbox.

Increasing EOB Response Rates

Besides introducing members to the EOB services verification process in the Member Handbook, Nebraska Total Care will send an email to the member at the time of mailing an EOB to explain the purpose and encourage members to watch their mail for the letter and respond. This initiative is part of our ongoing efforts to increase EOB response rates.

Educating Providers to Prevent FWA and Erroneous Payments. Our provider Program Integrity education plan includes all the requirements of SOW Section V.J.5 Provider Outreach, Education, and Training. We educate providers about FWA prevention through the Provider Handbook, Provider Portal, the Nebraska Total Care website, regular training, and meetings with providers and provider associations. Our resource materials guide providers about appropriate billing, utilization issues, reoccurring FWA trends, and the correction and enforcement process.

Provider Services Staff for Provider Support. Staff includes our Provider Service Representatives, Provider Claims Educator, and Provider Network Liaison. Our Provider Claims Educator educates providers on available compliance resources including coding, billing, and documentation guidelines. Our claims educator identifies FWA and erroneous payment trends to guide provider communication and resource development. Our Provider Network Liaison, the Senior Manager of Provider Services, and our Provider Services team educate providers on the availability of payment policies and educational opportunities on the Nebraska Total Care website and Provider Portal.

Provider Resources. Resources include our Provider Services Call Center which is a toll-free telephone line in addition to our FWA compliance hotline. Our Provider Handbook serves as a reference for critical FWA prevention processes such as verifying a member's enrollment, our network provider credentialing process and criteria, and compliant medical record standards. The Nebraska Total Care website and Provider Portal are useful digital resources in compliance education. For example, our Provider Portal contains the following FWA prevention functions:

- Member Search and Check Member Eligibility: Providers can check eligibility using the date of service, member ID or last name, and date of birth.
- ADT Notification: An ADT notification displays for members with a recent ADT event in the last 12 months.
- Secure Messaging: Providers can securely message with Nebraska Total Care staff.
- Claims Audit Tool: Access to claims adjudication logic to understand our claim edits to ensure claim coding accuracy.
- Coordination of Benefits (COB): Displays active other insurance information for the member.

Our Provider Advisory Committee (PAC) established in 2017 includes representatives from large provider organizations in the State, ancillary provider groups, and individual providers. Nebraska Total Care's PAC meets quarterly to provide recommendations on member utilization, policy, and innovation. Our PAC discusses regional and State-specific issues, challenges, and barriers impacting providers and identifies opportunities to solve these problems. Our PAC committee includes provider representatives from critical access hospitals, physical therapy, occupational therapy, speech therapy, behavioral health (BH), and pharmacy. The dental representation will be added once the new MLTC Contract is implemented.

We also meet with provider groups and provider associations regularly at locations across the State open to attendance by network providers, association members, and other community stakeholders. We report the discussion and results of quarterly provider forums to Nebraska Total Care leadership and MLTC for oversight. Our regular meetings encourage open FWA communication, including a review of FWA issues and prevention strategies.

Applying Program Integrity Education Methods in Nebraska. Nebraska Total Care applies member and provider education

methods through the well-publicized member and provider resources, accessible and proficient staff, and effective education and training plans. We realize administrative efficiencies when members and providers use these tools in self-service via our websites and portals. We will continue to use Program Integrity education to reduce waste, increase compliance, and prevent FWA in Nebraska.

Future Education Priorities. We will continuously update and improve our education strategy based on over five years of incumbent experience in Nebraska, by implementing new technology developed by our parent company and applying lessons learned from Medicaid affiliates across the country. ***Our 2022 Member Education Plan includes an emphasis on service verification including the new parallel EOB email discussed above. Our 2022 Provider Training Schedule will incorporate both in-person and virtual town halls, provider orientations, and expanded offerings for clinical professionals within our network.***

Education as a Tool for Corrective Action. We take reasonable measures to correct member and provider behavior before dis enrollment or termination including education and counseling regarding violations or behaviors and suggestions for improvement. For example, we execute and oversee clear and effective corrective action plans (CAPs) with our network providers that establish accountability, clear timelines, and metrics to demonstrate compliance. **Table 92.A** describes one Nebraska Total Care SIU case resolved by FWA education and corrective action rather than termination.

Table 92.A Corrective Action Supported by Provider FWA Education

Case	Investigation	Resolution	Education
Our SIU opened a case on a behavioral health provider based on billing CPT code 90837 (individual psychotherapy 60) at a higher rate than peers.	A clinical record review determined that 8 out of the 54 records were missing documentation for date of service, service code definition was not met for time threshold and conflicting/inconsistent information.	Our SIU collaborated with the provider and agreed on claims reprocessing once recoupment of $761 was received, without penalty of timely filing for the provider.	After successful resolution, Nebraska Total Care re-educated the provider on appropriate billing and documentation standards.

93. Describe the Bidder's method and process for capturing TPL and payment information from its claims system. Explain how the Bidder will use this information.

Page Limit: 3

Program Integrity in Claims Processing and Payment

Nebraska Total Care has five years of experience and success administering coordination of benefits (COB), third party liability (TPL), and subrogation in MLTC claims. Since 2019, using the automated controls in our Management Information System (MIS), we have achieved over ***$530.1 million*** in Nebraska Medicaid TPL savings. These savings include over ***$34.1 million*** from COB cost avoidance, over ***$486 million*** from COB processing, and over ***$9.9 million*** in cost recoveries. We realize our TPL success through claims automation, training for providers, system edit controls, and data exchanges with leading TPL vendors specializing in Medicaid and public sector TPL identification and post-payment recovery. Our policies and procedures center on Medicaid as the payer of last resort to determine the liability of third parties to pay for services, cost avoidance, and recover liability from responsible party sources. Our TPL policies and procedures include cost avoidance activities, methods for identifying other insurance, payment recovery activities, and subrogation. Nebraska Total Care complies with all TPL State and Federal requirements specified in SOW Section V.S. Claims Management, specifically subsections 15 through 17 for Third-Party Liability and Coordination of Benefits and Attachment 13 Reporting Requirements in the Third-Party Resource report.

Method and Process to Capture TPL and Payment Information

COB Center of Excellence. Nebraska Total Care collaborates with our parent company's COB Center of Excellence to develop and implement innovative TPL approaches that contain health care costs and reduce provider administrative burden. The COB Center of Excellence focuses on receiving and validating other insurance, updating COB business rules, process optimizations, analytics, and post-payment recoveries. This team includes experts on COB cost avoidance, processing, and recovery. We identify and implement procedures and systems for custom Nebraska Total Care COB and payment recovery processes to collaborate with providers and Subcontractors and report to MLTC.

Nebraska Total Care uses algorithms to identify TPL and increase pre-payment cost avoidance proactively. These follow-up efforts exemplify Nebraska Total Care's commitment to continuous improvement and efficiency using best practices from across our affiliate health plans. In 2021, we implemented a new claims pre-payment review module to enhance our ability to identify members who may have other primary insurance coverage. The new module enhances our ability to review provider claim submissions, notify providers of other primary coverage through their Explanation of Payment (EOP), and update our TPL records with other carrier information for more accurate billing and adjudication. In this enhanced process, providers also receive and access other carrier information more quickly.

Identifying TPL. We identify, manage, and apply member TPL data through multiple methods governed by our COB, TPL, and Subrogation Policies and coordinated by our Claims and Payment Integrity Departments. Our Claims Department oversees any COB or TPL applied at claims payment. Our Payment Integrity Department manages COB or TPL overpayments, including standard COB after claims payment and subrogation settlements. We make every reasonable effort to determine the liability of third parties.

MLTC Enrollment File. Through our HIPAA-compliant MIS, we receive MLTC's 834 enrollment files through an Electronic Data Interchange (EDI) process. MLTC's 834 enrollment files are received by our Unified Member View (UMV) system, which centrally houses current and historical member information. UMV employs a master data management approach to collect, store, and distribute member data we receive from our State partners to applications requiring that data for appropriate COB/TPL processing, including our Claims Processing System. This data distribution includes the eligibility systems of Subcontractors and vendors needing the information, such as vision, dental, and non-emergency medical transportation.

If the TPL data from MLTC differs from the information we have received from any other source, we report TPL discrepancies back to MLTC in the specified format. We include all TPL resources identified for members from all available sources as part of our submission to MLTC, including TPL identified by all vendors.

Additional Identification Methods. In addition to third-party resource data in the 834 file, we load and use TPL data received from submitted claims, provider and member interactions with our Provider and Member Service Representatives (PSRs/MSRs) and vendors. We bring all TPL information together in UMV and our Claims Processing System, which links to a member's unique Medicaid ID assigned by MLTC. **Table 93.A** describes examples of Nebraska Total Care's commitment to TPL discovery. We use this information to validate other insurance, update member records, report TPL monthly to MLTC, and conduct cost avoidance and payment recovery activities.

Table 93.A TPL Identification Methods in our Comprehensive Claims Processing Approach

Method	Description
Point of service investigations	Nebraska Total Care staff use member and provider interactions as an opportunity to identify TPL. Our integrated Customer Relationship Management (CRM) platform allows our PSRs/MSRs to capture TPL information while interacting with the member or provider such as a new member welcome call or other telephone interaction. Additional routine discovery processes include Health Risk Assessments (HRA) and prior authorization reviews. In addition, Care Managers can create and send a claims note in our Care Management platform, TruCare Cloud, for review by our Payment Integrity team.
Provider education	We educate providers on the importance of identifying TPL information at provider orientations, during ongoing training, in our Provider Handbook, and through resources on our secure Provider Portal. Key topics include submitting denial notices from third parties, accident details, medical records supporting other liable parties, or Explanation of Benefits (EOB) and payment information from a third party. Our provider agreements include TPL provisions such as identifying TPL coverage and seeking TPL payments before submitting claims.
Provider Portal	Our secure Provider Portal allows provider users to see TPL information on record for a member as part of their normal process before claim submission to Nebraska Total Care. The Provider Portal allows providers to submit TPL documentation and upload images. In addition, a provider may enter a claim directly via our HIPAA-compliant direct online claim entry tool with logical field checks for other insurance and provider alerts.
Vendor partner support to identify other insurance	Through our MIS, we securely send member data to our recovery vendor partners who reconcile the data against a regularly updated, nationwide insurance eligibility database with more than 1.5 billion insurance carrier eligibility records. Our recovery partners review access coverage information from over 1,250 different sources, mainly other insurance carriers. If a match occurs, our recovery partners verify coverage directly with the other carrier through online or telephone contact and send the results back to Nebraska Total Care. We load this member-level TPL and other carrier information into UMV, which feeds our Claims Processing System for cost avoidance.

Effective Response to Claims System Information. UMV, updated with the TPL identification methods described above, integrates with our Claims Processing System to support the collection, maintenance, and application of TPL in claims processing. **Table 93.B** demonstrates our effective response to claims system information and the savings achieved since 2019 by category.

Table 93.B Summary of Nebraska Total Care's January 2019 to March 2022 COB and Payment Integrity Savings

COB/TPL Metric	Description	Amount Saved
COB Cost Avoidance	The amount we save denying a claim received without an EOB and other insurance coverage effective on the date of service billed.	$34,134,350
COB Processing	The amount we save paying as secondary on a claim and processing applicable TPL.	$486,086,576
Cost Recoveries	The amount we save by recovering overpayments due to other insurance coverage found after payment.	$9,916,715
Total	**COB and Recovery amounts combined**	**$530,137,641**

Automated Controls at the Point of Adjudication. At adjudication, our Claims Processing System enforces TPL cost avoidance when a third party should have paid a benefit by suspending claims submitted without required payment information from a primary payer such as an EOB. Our system pends or denies the claim based on information contained within the member's TPL record and notifies the provider of the reason for denial, including details on TPL related to the claim. If we receive sufficient information from a third-party payer, we deny claims that have been denied by that payer for reasons related to the provider or member's failure to follow third-party procedures (such as failure to obtain prior

authorization). When a submitted claim includes TPL information, we process the claim to pay only our Nebraska Total Care allowable amount exceeding the amount of the third-party liability for that claim. Nebraska Total Care pays any member co-payment, coinsurance, or deductibles in TPL claims. Subcontractors that pay claims follow similar processes for TPL cost avoidance.

Compliance in TPL Exceptions

Nebraska Total Care's automated controls accurately process TPL exceptions such as payments for services to members covered by Indian Health Protections, EPSDT, DHHS child support services, or services from a commercial provider payer. Using a post-pay recovery policy and in accordance with MLTC's billing policies and procedures, we will pay for the full amount of applicable services and then seek reimbursement to pursue recovery from liable third parties.

Claims Analyst Oversight. Our Claims Analysts use the workflow capabilities of our Claims Processing System to track and complete tasks related to claims pended by automated claims processing software for potential TPL. This workflow system produces an online task list for the analysts with specific actions applicable to the pended claim. When processing a claim with an EOB attachment indicating TPL is present but there is no TPL assigned in our member records, the analyst applies TPL to the claim. Our system then updates the member record with the TPL information from the EOB, which automatically applies in subsequent claims for the member. As part of our insurance verification process, we use Machine Learning to efficiently assist our Claims Analysts to verify member other insurance coverage and update our Claims Processing System to ensure accurate payment.

Post-Payment Recovery. Nebraska Total Care treats recoveries and subrogation collected outside our Claims Processing System as offsets to medical expenses. We only pursue post-payment recoveries from third parties, never from members, and seek recovery within 60 calendar days after the end of the TPL identification month. If we adjust a claim due to TPL found after the claim is paid, we will report cost recovery/cost adjustment through the MLTC encounter process, including denials.

Recovery Vendors. We augment our TPL identification processes through collaboration with several external, nationally recognized recovery vendors for TPL identification and post-payment recovery. We work closely with these vendors to recover payments in case we were not aware of TPL when services were paid and to identify and pursue potential TPL payments. We provide our recovery vendors with claims data feeds including prescription, vision, dental, and emergency dental services. If they determine that a claim is related to TPL for a member with other insurance, the recovery vendor initiates recovery of the overpaid TPL dollars from the insurance carrier and requests reimbursement to Nebraska Total Care for the payment amount.

Subrogation. Nebraska Total Care securely integrates with leading health payment integrity and recovery services to ensure the appropriate administration of Medicaid funds and seek reimbursement in accident/trauma-related cases when claims in aggregate equal to or exceed $250 for a Contract year. Nebraska Total Care uses industry-leading vendors that further validate our claims and recover overpaid TPL dollars for post-payment recoveries related to subrogation, malpractice claims, and product liability. These vendors open subrogation cases primarily through leads, such as attorney letters, and data mining of our paid claims for trauma/accident codes. Using sophisticated tracking software, these partners know the status of each case at any time, tracking cases to recovery completion and closure. After confirming malpractice and product liability, the vendors bill the liable parties on behalf of Nebraska Total Care.

Supporting MLTC. Nebraska Total Care assists MLTC in identifying members with access to other insurance. We will continue to provide MLTC with third-party resource information in the format requested by MLTC, collaborate with MLTC or its cost-recovery vendor, update and adjust the encounter data for appropriate payment, and assign all estate recovery activities to MLTC. To demonstrate TPL cost avoidance and recovery efforts to MLTC, we will submit our procedures for identifying TPL and administrating payment 45 days before the new Contract Start Date. We will report the amounts recovered and members with third-party coverage monthly to MLTC in the Third-Party Resource – Health Coverage report of Attachment 13 – Reporting Requirements providing our data on instances of TPL.

RFP 112209 O3

B. Technical Approach

V.Q Provider Reimbursement

V.Q Provider Reimbursement

94. Provide a detailed description of the Bidder's approach to implementing a value-based purchasing model with providers. Include at a minimum the Bidder's:

• Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets

• Approach to identifying initiatives and performance measures on which to focus, proposed engagement strategies to encourage provider participation, incentives the Bidder will use, and methodology and timing for determining if providers have met requirements

• Discussion of best practices and lessons learned.

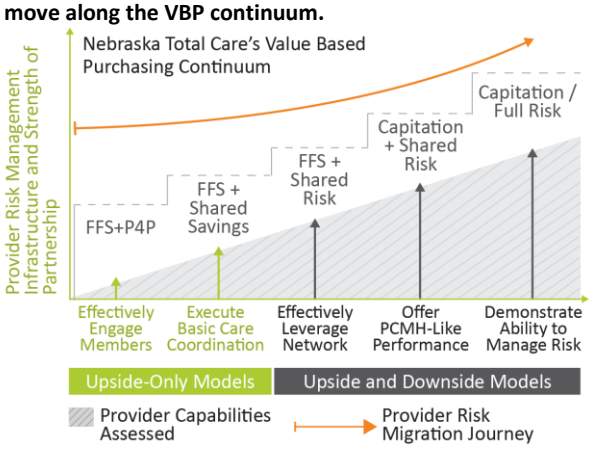
Page Limit: 5

Nebraska Total Care is a market leader in deploying innovative reimbursement and partnership models to increase access, improve health outcomes, provide better care, reduce costs, and improve member and provider experience, offering a combination of Value Based Purchasing Models (VBP), quality incentives, and risk arrangements. ***Currently, 95% of our members are served by providers participating in VBP models, including 55% of members assigned to a medical home participating in Shared Savings or Shared Risk Agreements and an additional 40% assigned to a medical home participating in a P4P incentive program.*** We are the only Medicaid MCO in the State offering a VBP featuring both upside and downside risk along with a risk agreement option that includes PCP capitation, allowing providers an opportunity to earn a significant surplus for achieving improved quality outcomes and cost efficiencies. Our VBPs comply with all requirements in 42 CFR 422.208 and 422.210, 42 CFR 434.6, and the Scope of Work.

Philosophy Regarding VBP and Risk-Sharing Agreements

For Nebraska Total Care, VBP is more than a contracting strategy; it is a key to our broader mission to improve the health of our community, one person at a time. We value our provider partnerships and foster a collaborative environment that encourages and rewards high performance and supports providers' progress via a continuum of VBP arrangements. ***Our VBP philosophy is to evaluate providers' readiness and offer a tailored program of hands-on support and data-driven tools to accomplish quality goals and improve Care Coordination and health care outcomes.*** Our approach supports MLTC's priorities to motivate providers to establish and attain goals, improve member health and satisfaction, and ensure care is delivered in the most cost-effective and appropriate setting. We identify providers' strengths and weaknesses, maximize their skills, and incentivize them in innovative ways to improve health care delivery. We leverage our experience and providers' expertise to successfully implement VBP initiatives that:

Figure 94-1. Nebraska Total Care supports providers to move along the VBP continuum.



- ***Align appropriate programs*** and create a credible pathway for providers to gradually adapt to VBP models
- ***Provide actionable insights*** to providers and help them identify opportunities for improvement
- ***Support providers through cross-functional teams*** that provide expertise in key clinical, quality, and operational areas
- ***Improve quality and risk gap scores*** through effective member engagement strategies
- ***Incorporate health equity*** to incentivize and support equitable access to services and improved health outcomes

Nebraska Total Care's ***QualityPATH VBP programs*** accommodate Providers at different stages of VBP adoption. Our VBP opportunities are available to all provider types: Primary Care Providers (PCP), Behavioral Health (BH), and other specialists, including non-emergency medical transportation (NEMT), FQHCs, tribal health providers and Indian Health Services, Rural Health Clinics (RHCs), hospitals, academic facilities, and accountable care organizations (ACOs). We offer a progressive pathway to support providers at every level of experience in participating in VBPs and taking on risk. We tailor our VBP approach to align provider success with improving member wellbeing, driving meaningful improvements in health and health equity, and managing the total cost of care.

Evidence of Effective Use of VBPs to drive quality. Nebraska Total Care has implemented payment reform strategies to effectively increase member engagement in preventive care, increase access to BH services and improve health outcomes.

Increasing member engagement in preventive care. From 2019 to 2021, we achieved significant HEDIS measure improvements within our Primary Care/medical home Incentive Pay-for-Performance (P4P) Program: ***31% increase in childhood immunizations, 15% increase in children's lead screenings, and 13% increase in controlling high blood pressure.***

Improving outcomes for members with complex needs. In our experience, assisting providers in engaging members with

complex needs is crucial for helping them meet their performance metrics. As part of our VBP approach, we meet monthly with providers to discuss strategies for serving members with high utilization trends that impact their quality scores. Our cross-functional team is comprised of representatives from our VBP Strategic Partnership Program team, Case Managers, Care Coordination, and Quality team members who work with providers to develop member-specific interventions for correcting ED overutilization, chronic readmission, and treatment plan adherence. We effectively support providers in managing members with the most complex needs, promoting engagement in VBPs, and driving quality.

Meeting Member 'John' Needs to Improve Quality of Life. John is a member with heart issues, back/hip pain, obesity and mobility issues. He is only able to navigate with a walker and lived in a second floor apartment without an elevator. As he was unable to walk down the stairs unassisted, his housing situation made it difficult for him to participate in services and integrate into his community. Our care manager worked with John and his provider to identify a first floor apartment. They arranged transportation, scheduled a PCP visit, and coordinated telehealth services. As a result, John experienced improved quality of life and increased engagement in services.

Enhancing care for members with BH needs. Nebraska Total Care's innovative BH incentive program rewards providers for engaging members in timely and appropriate care that leads to improved outcomes and community tenure. Providers receive bonus payments for the following: timely treatment initiation and member participation in ongoing services, assessment completion, and community tenure (as measured by reductions in ED visits and timely outpatient visits after discharges). When determining bonuses, we consider member risk levels and adjust payments accordingly to account for the additional resources needed to engage and serve members with complex needs. Our initial program with Community Alliance in Omaha and CenterPointe in Lincoln has shown early successes. ***Community Alliance and CenterPointe have met treatment initiation measures for more than 40 members and both achieved community tenure targets.***

Approach to Identifying Initiatives and Performance Measures

Nebraska Total Care aligns our initiatives and performance measures with the State's priorities and goals and national standards. Our VBPs incorporate HEDIS metrics and other elements such as the use of Z-codes and member experience to promote a whole health approach. This allows us to focus providers on common quality goals, driving systemwide improvement. For example, we select measures that correspond with the State's emphasis on MCO quality payment programs, maternal and child health initiatives, and BH initiatives. Whenever possible, we promote alignment with other payers to reduce provider administrative burden. ***Through our high-touch provider support model, we have seen a 31% increase in the percentage of members served by providers participating in risk-based contracts from 2020 to 2022.***

When determining specific initiatives and performance measures to include in each provider's contract, we take an individualized approach. Our VBP models recognize individual group variations and include initiatives that reflect the availability of services and challenges providers face in their community. Working with each provider, we evaluate operational readiness including available resources and infrastructure, assess their capacity to take on risk and review quality data performance including HEDIS scores, care gap lists, utilization data. We consider provider size and geography (rural, urban, and frontier), services delivered by the provider, their experience with VBP, and member needs. Providers give input on performance measures and other improvements through discussions with our Strategic Provider Partnership Director and Strategic Provider Partnership Manager. For providers who are new to VBP, we include process measures that evolve to support a gradual introduction to VBP and encourage provider retention. We review and update VBP programs based on historical performance and state-defined QPPs. For example, we enhanced our program to analyze performance metrics by child and adult populations, enabling us to target improvement efforts.

> "Our work together to learn and implement value based contracting (VBC) has been positive for Community Alliance. The approach that NTC takes is focused on helping to improve a member's engagement in treatment and ultimately to help them in their recovery."
>
> *- Aileen Brady, Chief Operating Officer, Community Alliance*

Proposed Engagement Strategies to Encourage Provider Participation

Nebraska Total Care encourages provider participation in VBPs by working alongside them to meet members' needs and increase their performance on quality metrics. We approach each provider group as a unique entity and work with them on communication, reporting, meeting structure, and care coordination. Together, we create a VBP model that works with their operational structure, promoting success. We offer individualized support through our dedicated staff, recognize providers that deliver high-value care to promote retention, deliver actionable data that enables providers to track performance and prioritize member engagement and educate providers on our VBP programs.

Individualized support through dedicated staff. Our dedicated staff specifically supports providers in achieving success with VBP. Our Strategic Provider Partnership Director and Strategic Provider Partnership Manager meet regularly with providers for actionable data sharing and Care Coordination. Quality Practice Advisors (QPAs) provide care gap closure, appropriate coding, and HEDIS education to providers to maximize quality outcomes for members. Our dedicated staff monitor provider performance; educate and train providers on the drivers behind their performance; assist with HEDIS reporting, identify practice-specific care gaps, and provide recommendations for improvements. ***Our highly responsive, community-based teams work statewide to mitigate issues immediately.***

Provider Recognition. Nebraska Total Care recognizes high-performing providers to show our appreciation and share best practices. For example, we selected two practitioners or groups each year for our ***Physician Summit Award for Excellence in Care***, based on exemplary performance on HEDIS quality measures. Our Physician Summit award winners include Dr. Rebecca Lancaster and Dr. John Tubbs - ***recipients of the Governor's Medicaid Provider Excellence recognition award.***

Delivering actionable data to drive improvement. Nebraska Total Care tailors reports to give providers actionable data to inform member engagement and enable them to track their performance on quality metrics. Provider Analytics delivers data (cost, utilization, quality measures, member engagement) that providers can interact with via custom selection and drill-down capabilities. Providers can use exporting and reporting capabilities to identify factors behind clinical and cost performance, and strategically target clinical actions. To drive clinical decision-making at the point of care, providers can access ***Patient Analytics*** through our secure Provider Portal. Providers can access their disease registries; view evidence-based care gaps; identify quality improvement opportunities and improve their Care Management functions. Patient Analytics offers member-specific diagnoses, medication, lab, and care team data, allowing providers to prioritize member engagement to close care gaps and improve their quality scores. Nebraska Total Care further invests in ***advanced data analytics tools*** to meet specific provider needs. For example, we have partnered with Quartet to provide data analytics reporting and a referral/assessment tracking platform to support our BH incentive model. Quartet's technology and services equip providers with tools to measure outcomes and successfully adopt new payment models. We meet monthly (and ad hoc) with Quartet and provider teams, to support program progress and analyze claims data and assessment information captured in the platform. Providers effectively use these reports to engage members and earn incentives.

Nebraska Total Care Delivers Actionable Data to Drive Results

Our provider partner, CenterPointe, used the member list shared by Quartet to prioritize member outreach and engagement. Equipped with this actionable information, their community-based outreach team connected with members to address their social needs and engage them in BH services. Recognizing the value of using data to inform member engagement, CenterPointe incorporated data elements from the Quartet report into their EHR, enabling them to identify members with high risk levels and track visits, last date of service, diagnosis, date of last assessment, and assessment type. CenterPointe has effectively used this data to drive performance improvement, allowing them to earn over $1400 in bonus payments since Q4 2021.

Provider Education. During contracting discussions with providers, we introduce them to VBP opportunities; explain how programs work; and describe the training and support we provide to ensure success, how they can improve member care and outcomes, and how the program can lead to improved job satisfaction for their staff. We include comprehensive VBP program descriptions in our provider orientation and provider handbook, and routinely discuss VBP during ongoing provider training, in newsletters, and during visits with Provider Relations staff. Providers who are interested in participating receive a comprehensive cost-benefit analysis that includes an estimate of their potential for increased reimbursement. Ongoing provider training addresses new requirements or initiatives, program priorities, incentive structure, and performance issues. Provider education is conducted in various modes including office-based and group training, e-learning, free BH and nursing CEUs, and webinars. Our ***Practice Improvement Resource Center*** is an organized, searchable compendium of information on evidence-based and best practices; practice guidelines; multi-media content; and interactive tools to help providers manage clinical, operational, and technological aspects of their practices.

"Specifically, I want you to know that we are proud to be working on a value-based contract with NTC and Quartet that focuses on people in our community who struggle the most and need an intensive approach to find a positive solution. We believe our collaborative is groundbreaking and results in positive outcomes for all concerned."

-Topher Hansen, JD, President/CEO, CenterPoint

Provider engagement to address members' whole health needs. We know that member engagement in health care is often impacted by social determinants of health (SDOH) and health inequities. Through monthly care coordination meetings, we work with providers to address these issues and connect members to appropriate care. Using proider input

and data review, we identify members with high ED utilization, readmissions, risk for hight pharmacy spending, and SDOH needs. We then work with the provider to address the member's specific needs. For example, we connect members to utility assistance, housing, and stable food sources. By meeting the member at their point of need, we build trust and remove barriers to care, leading to appropriate service utilization for the member and improved quality scores.

Program Incentives

Through our ***QualityPATH VBP programs*** (shown in **Table 94-1**), Nebraska Total Care intentionally creates flexibility for a broad array of providers to increase health equity, improve member and community health outcomes and reduce costs. We continuously identify and implement strategies and initiatives to improve the health of our members, leveraging our Health Equity Improvement Model which uses qualitative and quantitative data to identify and remove health disparities. We are investing in and engaging providers by adding Equity-Based Contracting (EBC) as a new dimension to our VBPs with a new health equity incentive based on population risk level.

Table Q94-1. Our QualityPATH VBP Models meet providers where they are to drive quality.

QualityPATH Premier (LAN Category 4 – Capitation+Shared Risk)		
VBP Model	**Description**	**Providers Reached**
Shared Risk & PCP Capitation (Model 1)	• PMPM reimbursement for the cost of care for assigned TANF members. • Providers share in savings generated by engaging members in preventive care, reducing potentially preventable events and managing member outcomes. • Providers reimburse the Plan for exceeding costs and/or not meeting utilization targets related to potentially preventable events. • Provider groups select quality measures from the designated list of HEDIS gaps and focus on closing the gaps within the calendar year.	Large FQHCs
QualityPATH Plus (LAN Category 3B – FFS+Shared Risk)		
VBP	**Description**	**Providers Reached**
Total Cost of Care	• Providers share in savings generated by engaging members in preventive care, reducing potentially preventable events and managing member outcomes. • Providers reimburse the Plan for exceeding costs and/or not meeting utilization targets related to potentially preventable events. • Provider groups focus on HEDIS and quality gap measures.	Multi-hospital ACO
QualityPATH Basic (LAN Categories 2B, 2C – FFS+P4P, FFS+Shared Savings))		
VBP	**Description**	**Providers Reached**
Equity-Based Contracting (new)	• Providers earn incentives for increasing HEDIS rates for specific populations with identified health disparities. • Pilot program with Great Plains Health, CAPWN, Children's of NE, and OneWorld to facilitate access to care for all members and reduce identified health inequities. • Using lessons learned from the pilot, we will expand statewide.	PCPs, FQHCs, PCMHs, RHCs
SDOH P4P Program (new)	• Providers earn incentive payments for submitting z-codes. • We will consider adding an incentive for provider referrals for members to community-based organizations; closed-loop referrals documented in Findhelp.	PCPs, PCMHs, RHCs, and FQHCs
Dental (new)	• Dentists will earn incentives for completing a tailored SDOH mini-screen. • Dentists will submit the information via the Provider Portal, which will cue Care Management staff to follow up with the member.	Dental providers
Upside Only Shared Savings	• Providers share in savings generated by engaging members in preventive care, reducing potentially preventable events and managing member outcomes. • Provider groups focus on HEDIS and quality gap measures.	SCH-hospital ACO, Physician IPA-ACO
Primary Care/Medical Home P4P Program	• P4P program that encourages appropriate and timely preventive health and disease monitoring services per evidence-based clinical guidelines and incentivizes provider outreach to members. • ***From 2019 to 2021, we achieved significant improvements in childhood immunizations, children's lead screenings, and controlling high blood pressure.***	PCPs, PCMHs, FQHCs, and RHCs statewide with >50 assigned members
Integrated Risk Gap Closure Program	• Providers receive incentives for closing gaps in care for assigned members. • ***From 2020 to 2021, we reached more than 62% of members in the program, and providers more than doubled their program earnings year over year.***	All PCP offices, any membership volume

NEMT Pay for Performance Program	• Providers earn incentives for meeting quality targets (e.g., wait times) and contributing to a reduction in transportation-related complaints. • ***Q1 2022 results show a 20% decrease in all driver complaints, resulting in providers earning initial bonuses for performance.***	High volume NEMT providers in Douglas, Lancaster, & Sarpy counties
Enhanced Service Pharmacies Complex Care Program	• We reimburse pharmacists for expanded medication management and provide bonus payments for meeting adherence-related HEDIS measures. • ***Nearly 200 members are covered by pharmacists in this program who have accrued approximately $60,000 in bonus payments since June 2021.***	Pharmacies
Notification of Pregnancy Incentive	• Providers receive incentive payments as part of the following programs: ○ Timely and complete submission of the NOP Form; submission of the Heritage Health Obstetric Needs Assessment Form ○ Appropriate administration of 17P and positive birth outcomes • ***Increased engagement with pregnant members has led to a 14% decrease in NICU stays from 2020-2022.***	PCPs, FQHCs, PCMHs, RHCs, and OB/GYNs
Behavioral Health P4P Incentive	• Providers receive incentives for meeting quality targets for treatment initiation, assessment completion, and community tenure (reduction in ED visits, outpatient follow up after discharges). • ***For our initial pilot, Community Alliance met treatment initiation measures for 20 members and achieved community tenure targets.***	BH Providers, CMHCs

Methodology and Timing for Monitoring Requirements for Participation

Nebraska Total Care monitors provider performance on quality metrics monthly. Through monthly performance scorecards, providers can track their progress, see how they improve over time, and adjust their practices as needed. Key measures include quality, cost, utilization, admissions and readmissions, engagement, and loyalty. Based on program performance and provider feedback, we modify our strategies and initiatives to reflect changes in practice management, increase provider accountability, and incorporate new performance goals. Payment frequency depends on the type of VBP initiative in which the provider participates. For ***QualityPATH*** Basic programs, we pay incentives two to three times throughout the year with an annual final payment that allows for a three-month claim run-out. Nebraska Total Care calculates and pays incentives three times during the year for providers participating in our QualityPATH Plus and Premier programs. We complete an annual reconciliation of performance and payments in 180 days after year-end.

VBP Best Practices and Lessons Learned

Nebraska Total Care's VBP success is due in large part to our collaborative partnership with providers and our willingness to deploy innovative strategies and best practices. As shown in **Table 94-2**, our approach to VBP builds on the lessons we have learned by working side-by-side with providers to deliver high-quality care to Nebraskans for over five years.

Table 94-2. Nebraska Total Care's VBP approach leverages best practices gleaned from our lessons learned.

Lesson Learned	Nebraska Total Care Best Practice
Engage providers in design and implementation	• We partner with providers to customize our VBP models for each provider based on the services they provide, panel size, geography, and member demographics.
Actively encourage and support improvement efforts	Our dedicated staff support provider success with VBPs. • Strategic Provider Partnership Director and Strategic Provider Partnership Manager meet with providers to discuss data sharing and Care Coordination. • QPAs provide care gap closure, appropriate coding, and HEDIS education.
Include primary and specialty providers that impact specific targets (e.g., BH providers)	• We offer VBP programs for multiple provider types (dental, BH, transportation, pharmacies, PCMHs, PCPs, FQHCS) with specific performance measures based on member needs and services provided.
Give providers frequent, timely, and actionable feedback	• Through monthly performance scorecards available on our Provider Portal, providers can track their progress, see improvement, and adjust their practices.
Transparent communication to ensure providers understand operational requirements and responsibilities	• During contracting discussions, we introduce providers to VBP opportunities and describe our training and support to ensure success and improve outcomes. • For providers who are new to VBP, we include process measures that evolve over time to support a gradual introduction into VBP and encourage provider retention.
Timely & transparent payment for provider retention in VBP	• We pay providers timely – multiple times per year with an annual reconciliation. • Our monthly dashboards enable providers to track performance and payments.

Supporting members with complex needs to promote engagement and drive quality	• Through monthly care coordination meetings, we support providers in serving members with complex needs, helping them to meet their performance goals while transforming the health of the community, one member at a time.
Set performance targets using national and local benchmarks	• We align VBP performance targets with HEDIS measures and state QPPs to focus providers on common goals and support benchmarking.
Work with providers to identify and resolve unanticipated, adverse changes in outcomes	• Our dedicated staff monitor provider performance; educate and train providers on the drivers behind their performance; assist with HEDIS reporting and using tools; identify practice-specific care gaps; and support improvements.

95. Provide a description of the Bidder's proposed MAC program, including methods for setting MAC prices, criteria used to select covered MAC drugs, process for resolving disputes regarding the MAC value, how the Bidder will evaluate its MAC program, and any other program components the Bidder considers important for achieving MLTC's goals. Describe the Bidder's experience with establishing MAC programs in other states and highlight strengths and challenges.
Page Limit: 6

Description of Proposed MAC Program

Nebraska Total Care's Maximum Allowable Cost (MAC) program is supported by our Pharmacy Benefit Manager (PBM), CVS Caremark (CVS). CVS has 20 years of experience developing and implementing MAC programs tailored to meet the needs of Managed Medicaid clients. The PBM MAC team is dedicated to reducing the cost of care by partnering with the State to ensure the best solution is in place for Nebraska. In addition, the Nebraska Total Care Pharmacy Team reviews and facilitates the resolution of MAC reimbursement inquiries received at the plan level, educating providers on how to submit a MAC appeal, and often providing network pharmacies with alternative generic NDCs available that may have a more favorable acquisition cost or reimbursement.

Our PBM's comprehensive MAC program uses industry best practices to promote cost containment strategies leveraging appropriate generic utilization while ensuring fair reimbursement for pharmacies and adhering to the MLTC Preferred Drug List (PDL). The MAC list includes more than 2,100 Generic Product Identifiers (GPIs), representing approximately 92% of all available generics, and will be provided to the State quarterly. CVS will ensure pharmacists have accurate, timely information for all claims submitted. We require the PBM to update all retail and specialty drug files at least every seven days, though they often update files sooner.

Providers can access the PBM Pharmacy Portal to obtain current and upcoming MAC prices based on the PBM's MAC price update schedule, including for Medicare Part D plans. To locate MAC price information, providers use the "MAC Price Look Up" feature of the Pharmacy Portal, available through a secure website or via email upon request.

Methods for Setting MAC Prices

CVS uses aggregate information from wholesalers and third-party sources to establish MAC prices for generic and multi-source brand products at a product level by reviewing marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span and similar nationally recognized references, MAC lists published by CMS, National Drug Acquisition Cost (NADAC) published by CMS, Predictive Acquisition Cost (PAC) developed by Glass Box Analytics, and wholesalers and retail pharmacies. CVS reviews and updates MAC pricing based on market at least weekly. We provide price changes on the PBM Provider Portal, and on the PBM and Nebraska Total Care websites.

Generic Reimbursement Methodology. The MAC list includes approximately 97% to 99% of generic claims and over 200 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. Due to the number of generic product manufacturers and market competition, generic prices can change often. Per contract requirements in Section V.Q.20, Nebraska Total Care has established an extensive MAC program to promote cost containment and has processes to ensure MAC pricing is appropriate and not routinely below the wholesale price available to pharmacies. MAC reimbursement methodology incentivizes pharmacies to purchase the most economically reasonable product and puts competitive pressure on wholesalers and manufacturers to sell their products at prices lower than MAC rates.

Criteria Used to Select Covered MAC Drugs

Generic drugs, whether identified by its chemical, proprietary, or non-proprietary name, are accepted by the FDA as therapeutically equivalent or interchangeable with drugs having an identical amount of the same active ingredient. A generic drug is generally equivalent to a brand drug deemed to require or otherwise capable of pricing management due to the number of manufacturers, utilization, and/or pricing volatility. When determining whether a product is eligible for a MAC price in the PBM's generic pricing program bioequivalence, the PBM considers the following factors: number of vendors in the marketplace, product availability, and claims volume. ***New generics are typically added to the MAC list within 30 days after they are readily available from more than two generic A-rated vendors.***

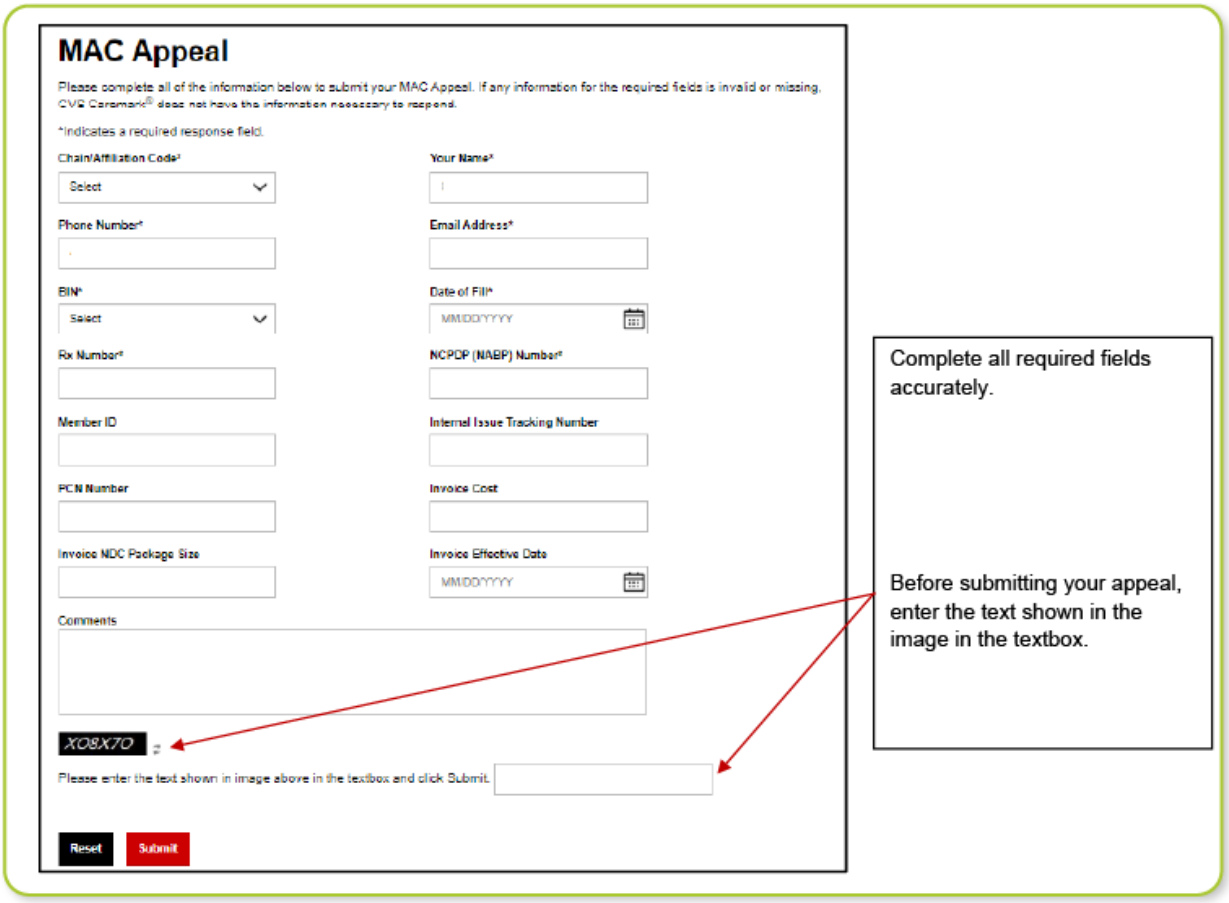
Prescription drugs will be placed on the MAC drug list based on the following criteria:

- Availability of generic products in the marketplace
- Generic drug has been on the market past the Exclusive Generic timeframe
- Product is rated by the FDA in relation to the innovator brand drug (A-rated by the FDA Orange Book)
- Marketable discount difference between the price per unit versus what could be captured through a discount off the average wholesale price (AWP)
- Price differences between the brand and generic products
- Clinical implications of generic substitution

Process for Resolving Disputes Regarding the MAC Value

We offer an appeal process to allow a pharmacy to contest a listed MAC rate. We review and respond to MAC appeals within seven calendar days. To dispute the MAC value, the pharmacy goes to the PBM website as shown in **Figure 95.A,** downloads the Pricing Inquiry form, completes the MAC Appeal form, and submits it to the PBM along with the pharmacy's invoice for the disputed drug. The provider must submit the completed form within 60 days of the claim fill date. The PBM MAC pricing team receives and validates the request submission, logs the appeal information into their tracking system, and evaluates the appeal against numerous conditions and metrics to determine if they will increase the price. Examples of sources reviewed for making a pricing appeal determination include Medi-Span AWP pricing, fluctuations in MAC pricing, and feedback from our pharmacy partners.

Figure 95.A. We offer a MAC Electronic Appeal Form to reduce provider burden.



Once the MAC Management team has evaluated an appeal, they approve appropriate price increase determinations. The MAC Pricing team creates a standardized file to upload to the PBM's proprietary Claims Processing System, backdating the new price to the claim service date for all similarly situated pharmacies. To ensure accurate documentation of this process, the PBM updates its tracking system to reflect the determination and sends a response to the pharmacy within seven days.

Additional Review. The Director of Network Operations forwards any concerns requiring further research and resolution to the MAC Pricing Team for review. The PBM resolves exceptions identified during these reviews within two business days, and posts updates to the PBM's Claims Processing System accordingly. The PBM applies new drug prices retroactively to dispensed drugs and all network providers when it uploads the drug file.

How Nebraska Total Care Evaluates the MAC Program

We provide oversight to the MAC Program through an annual audit and a sample of appeals and MAC lists quarterly to the State. Monthly MAC appeal reporting is received from the PBM, reviewed, and monitored by Nebraska Total Care. Metrics evaluated include number of MAC appeals reviewed, number approved and denied, and number of determinations completed outside the required seven days requirement. Outlier trends in MAC appeal metrics, along with provider feedback received at the plan level, are monitored for appropriate MAC Program management and compliance with contract requirements.

Other Program Components Nebraska Total Care Considers Important for Achieving MLTC's Goals

PDL Configuration. Sometimes, a brand preferred drug list (PDL) drug may be preferred over an available non-preferred PDL generic medication. We have a proactive PDL configuration process between Nebraska Total Care, the PBM, and MLTC to ensure brand name preferred PDL drugs with generic non-preferred PDL equivalents are not reimbursed according to the non-preferred generic MAC.

Medical Necessity. Members, providers, and the public have access to our online pharmacy resources that show whether a drug is preferred and our medical necessity guidelines for all drugs that require prior authorization (PA) and step therapy, including non-formulary designations, appropriate utilization, and quantity limits. The PBM's pharmacy network contract requires participating pharmacies to dispense medications to patients, even if they believe the reimbursement rate is low. In this instance, the pharmacist is advised to follow the PBM's MAC pricing appeal process. A pharmacist is not allowed to deny service to a patient due to low reimbursement rates.

Monitoring and Oversight. We monitor compliance with drug file updates during meetings between our Pharmacy Director, Pharmacy staff, Clinical Account Manager, and the PBM's Account Executive and Account Manager.

Day-to-Day Oversight and Monitoring of Pharmacy Claims Processing. Our Pharmacy Director is responsible for day-to-day oversight and monitoring to assure the PBM's pharmacy claims processing meets MLTC specifications. The PBM's encounter submission and tracking system allows us to create customized reports and quickly review complete and accurate pharmacy data on members. If we identify processing discrepancies, our Pharmacy Director immediately makes corrections with the PBM, to assure appropriate pharmacy services are available for members. Examples of ongoing monitoring and oversight activities include the following:

- **System Testing.** Our Pharmacy Director routinely reviews testing data to assure claims payment accuracy of the MLTC pharmacy benefit and as needed when changes are made to the pharmacy Claims Processing System.
- **Monitoring Quantity and Days' Supplies.** Our Pharmacy Director and PBM staff work together to implement POS edits to prevent payment of questionable values for quantity and days' supply billed by pharmacies. Our POS messaging system stops a claim until we receive PA for drugs that have clinical monitoring, such as quantity limits, age limits, or duplicate therapy/dose consolidation concerns.
- **Quarterly Joint Operational Meetings.** We hold quarterly meetings with PBM staff to discuss operational and reporting issues along with potential enhancements, overall performance, and contract compliance.
- **Follow-Up on Reported Claims Processing Errors.** Our Pharmacy Director investigates pharmacy- and member-reported accounts of claims processing errors to ensure we take corrective actions as warranted.
- **Random Review of Claims.** We routinely audit a random sample of pharmacy claims to verify payment accuracy.

Claims Processing System Audits. In addition to our Pharmacy Director's day-to-day oversight and monitoring, the PBM undergoes an annual audit conducted by our parent company, Centene, and a URAC reaccreditation audit every two years.

Centene Annual Delegation Audit. Centene's corporate Quality Improvement (QI) Department, in conjunction with the corporate Pharmacy Department, audits the PBM annually. Health plans that subcontract with the PBM, such as Nebraska Total Care, are invited to participate in the audit.

Conducting a single audit, with health plan participation, ensures consistent application of standards and coordination of any corrective actions across all Centene health plans that manage pharmacy benefits as part of their state contracts. Centene corporate QI staff will provide annual delegation audit results as a report, which includes any corrective action plan (CAP), to Nebraska Total Care and the PBM within 30 days following the audit. Our Quality Assurance Performance Improvement Committee (QAPIC) reviews audit reports in quarterly meetings and may require operational policy or procedure changes in response to audit findings.

If we determine the PBM is out of compliance with contractual or regulatory requirements, we require a written and signed CAP that spells out a detailed action plan, expected, measurable results, and a due date for completion. The PBM must provide the CAP within two weeks of receiving our notice and complete the CAP within 30 days of our approval unless another period is agreed to in writing.

If the PBM fails to complete the CAP as specified, we may suspend or revoke the delegation of PBM services and issue a notice of material breach of contract and opportunity to cure, based on the PBM's breach of contract, allowing 60 days to cure. Finally, for specified reasons such as loss of insurance, we may terminate the contract immediately.

Experience Establishing MAC Programs

The MAC list development process involves reviewing marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span, wholesalers, and MAC lists published by CMS and retail pharmacies. Today, our contracted PBM manages 26 Medicaid health plan MAC programs.

Key Program Strengths

- Regular review of MAC list and pricing to ensure completeness and competitiveness
- Flexibility and customized pricing solutions
- Ongoing communication with the State-managed Medicaid plan
- Customized reporting
- MAC appeals process for pharmacies to challenge generic drug pricing in accordance with applicable laws

Key Program Challenges

- **Generic Reimbursement Varies.** Pharmacies are reimbursed according to contracted terms between the PBM or claims adjudication platform and the independent pharmacy, chain, or PSAO based on the lessor of logic, including a discount off AWP plus a dispensing fee, MAC plus a dispensing fee, ingredient cost submitted, or usual and customary cost provided by the pharmacy. Unique contracted pharmacy terms, no line of sight to pharmacy wholesale purchase price, and multiple drug pricing metrics make maintaining an up-to-date MAC list that is above the wholesale purchase price for all network pharmacies challenging.
- **Independent Pharmacies.** Independent Pharmacies do not generally have the same purchasing power as larger chains, and as such may purchase products at a higher acquisition cost. Independent pharmacies may join a PSAO or buyers group to take advantage of higher volume wholesaler cost savings. However, the MAC programs must balance cost containment strategies while routinely reimbursing independent pharmacies above wholesale costs.
- **MAC Legislation.** Evolving state MAC legislation represents the biggest challenge to effective MAC management. The PBM's MAC management team, along with PBM leadership, collaborate with health plans and State partners to maintain a process that adheres to the strictest MAC legislation for the entire client base.

96. Describe the Bidder's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the Bidder is unable to provide necessary services to a member within its network.
Page Limit: 2

Expeditiously Resolving Out-of-Network (OON) PAs and Payment Issues

Nebraska Total Care offers an expansive network of providers to meet the needs of Heritage Health members and exceeds access requirements outlined in this Scope of Work. We realize members may require OON services when they are unable to obtain medically necessary services from an in-network provider, have specialty care needs, or need to maintain continuity of care. Our policies and procedures ensure members can obtain timely authorizations for medically necessary services, and that providers are paid accurately and promptly. Our claims processing system is configured to provide reimbursement for OON Nebraska Medicaid-covered services delivered by Nebraska Medicaid enrolled providers according to Scope of Work requirements. We comply with all requirements related to payments to OON providers as required in 42 CFR and in RFP Section V.Q.9. Emergency services and family planning services do not require prior authorization (PA) regardless of whether the provider is a contracted provider; we allow members to receive family planning care from their provider of choice.

Established Members. When an established member needs OON services, Nebraska Total Care processes authorizations and reimburses the provider in accordance with direction from MLTC on OON provider reimbursement requirements. When medically necessary covered services cannot be reasonably obtained from a network provider, we authorize OON services. For OON providers to receive claims payment from us, they must be enrolled as a Nebraska Medicaid provider on the State-maintained provider enrollment file. As appropriate, we may develop standing referrals or Single Case Agreements (SCAs) with OON providers who agree to treat a member but are unwilling to contract with Nebraska Total Care.

Putting Members First for OON Family Planning Services

Our systems are configured to consider and reimburse for services aligned with member choice. ***In 2020 and 2021 we paid 76 OON providers for family planning services.***

To reduce the need and the quantity of SCAs, Nebraska Total Care has secured agreements with Sanford, Avera, and Monument Health in South Dakota to serve members in northeast Nebraska, and Colorado-based HCA Healthcare and Wyoming-based Cheyenne Regional Medical Center to serve members in western areas of the State. We also review SCA utilization patterns to identify OON and out-of-state providers to recruit into our network; examples include Davita, DCI, Fresenius, and Sanford Health.

For those situations where we have not secured an Agreement, we use SCAs to ensure seamless access to care for members and provide immediate remediation of network gaps when appropriate. When a need arises for health care services that are not currently covered under our network, such as a rare specialty or continuity of care need, we refer the request from the entry point (for example, Member Services, Care Management, Utilization Management (UM), or Network team) to the SCA team to review during a weekly call, unless more urgent attention is appropriate. When the SCA team determines the service is medically necessary, and there is no appropriate in-network option, the UM designee notifies the SCA negotiator to initiate negotiation with the OON provider within one business day for urgent situations and within three business days for non-urgent. Emergent care does not require PA or an SCA. Our SCA negotiator negotiates all SCAs for all non-contracted in- and out-of-State providers. We authorize the OON/SCA to provide coverage for medically necessary services with no in-network option while a provider is working through the contracting and credentialing process to become an in-network provider.

- The SCA team monitors OON service requests weekly. We approve SCAs when no participating provider is available for a particular medically necessary service, specialty service, or continuity of care needs.
- Medical management, in conjunction with contracting, identifies the nearest non-contracted provider and authorizes OON services.
- Once we finalize an authorization, the SCA negotiator will provide a proposal to become a participating provider or finalize SCA terms only when the identified provider is not willing to become a participating provider.
- If a member requires covered services from a provider type or specialty that is not within the travel standard, the UM department authorizes medically necessary covered services by an OON provider until a suitable network provider is available. Once authorization is finalized, the SCA team provides a proposal to become a participating provider.

> "Boston Children's Hospital had a medically complex child transfer for care from Nebraska. My team worked closely with Nebraska Total Care prior to the child's admission to ensure the transfer would be as smooth as possible. The team at Nebraska Total Care was fantastic and kept in frequent communication with the team at Boston Children's. Many of our patients have lengthy admissions and the team at Nebraska Total Care was able to work with the family to cover travel and lodging expenses, which was a great relief to the family."
>
> *- Julia Thomann, LICSW, Boston Children's Hospital*

New Members. When we identify new members as being in an active, ongoing course of treatment or within the second or third trimester of pregnancy, we complete timely authorizations to continue medically necessary covered services with an OON provider for up to 90 calendar days through the postpartum period or until the member can safely transition to a Nebraska Total Care network provider.

Continuing OON Care Beyond the Transition Period. For certain types of care, transitioning to a new network provider during a course of treatment may pose a risk to the member's health. Network providers may not accept the member as a new patient when they are in the middle of a course of treatment with another provider. For these situations, we authorize the continuation of services with the OON provider to ensure continuity and avoid disruption in care, such as when the member is receiving:

- **Transplant Services.** For members actively receiving transplant services at the time of enrollment, we will authorize continuation with the OON transplant provider through one-year post-transplant.
- **Chemotherapy.** For members receiving chemotherapy, we authorize continued treatment with the current OON provider until treatment is completed.
- **Services for Special Health Care Needs.** For members with special health care needs, such as children with intellectual or developmental disorders who have an established relationship with an OON provider, we authorize continued treatment with the established provider.

Processing Requests from OON Providers. OON services, except emergent care and family planning, require PA. Our public website includes this information and instructions on how to submit PA requests. OON providers may submit requests for authorization by calling or faxing our PA Department. Providers may call for Medicare HIDE SNP or Medicaid authorizations and can initiate their request during their initial phone call. Our OON provider webpage details how to reach a Provider Relations Representative. Provider Relations Representatives educate OON providers on our processes for requesting PA. They advise providers to consult the provider handbook and billing guide, posted on the provider website, regarding claims payment. Our Provider Relations Representatives are a direct line for help for providers experiencing any issues.

We process PA from OON providers using the same policies, procedures, and medical necessity criteria as those submitted by in-network providers and review these within the same timeframes. As required in Section V.H Grievances and Appeals, we issue decisions on PA requests as expeditiously as possible, but no later than 14 calendar days following receipt of a standard service request. If an expedited review is necessary, we decide as quickly as possible, but no later than 72 hours after receiving the request. We make every effort to issue decisions as quickly as possible and minimize administrative requirements for our providers and ensure members receive timely care. Once we issue PA for OON services, UM staff contact the OON provider to educate them on our policies, the PA scope, and any requirements for submitting clinical information or working with other providers to manage transitions of care. We give providers instructions for submitting claims and obtaining information via our provider billings guide on our website.

Resolving Payment Issues Expeditiously

We process claims from OON providers using the same processes and timelines used for in-network providers. Consistent with Section V.Q – Provider Reimbursement and the Deficit Reduction Act of 2015, we reimburse OON providers at 100% of the published Medicaid rate for covered emergency and post-stabilization services. During the initial 180 calendar days of the contract, we pay other covered and authorized OON services at 100% of published Medicaid rates. We adjudicate all claims, regardless of provider contracting status, in our core claims processing system, which accepts Julian time stamps indicating when a claim is received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link all available information and track our adherence to claims processing timelines. Upon SCA execution, we share a copy of the fully executed SCA with the claims team to allow for proper reimbursement methodology and rates to be applied upon initial adjudication. Our system checks for a provider's participation status before pricing during claim adjudication. According to SCA for the member/provider combination, we apply the appropriate reimbursement methodology and rates. We address payment inquiries by OON providers within three business days and in the same manner as inquiries submitted by contracted providers.

97. Describe the Bidder's proposed process for the annual year-end cost settlement with critical access hospitals.
Page Limit: 1

Process for Annual Year-End Cost Settlement with Critical Access Hospitals

Nebraska Total Care annually submits required cost settlement reports for Critical Access Hospitals (CAH) in accordance with MTLC cost reporting instructions and requirements in effect for the State Fiscal Year for which the cost settlement is required. Based on requirements outlined in 471 NAC 10-010.03F Payments for Services Furnished by a Critical Access Hospital and 10.010.06A, Payments for Outpatient Hospital & ED Services Furnished by a Critical Access Hospital, the payment for services of a CAH is the reasonable cost of providing the service, as determined under applicable Medicare principles of reimbursement. We understand that MLTC annually determines payment rates based on available funds appropriated by the Legislature. We agree to make all CAH inpatient payments utilizing interim per-diem rates with an annual year-end cost settlement that occurs at the end of each CAH fiscal year. Nebraska Total Care pays outpatient rates according to MLTC's calculations based on a cost-to-charge basis with an annual year-end cost settlement.

Process for Year-End Cost Settlement with Critical Access Hospitals

Nebraska Total Care submits all required reports related to annual year-end cost settlement processes with critical access hospitals. We use qualified accountants who understand information requirements and have established policies and procedures to oversee our cost settlement process, ensuring reports are accurate and complete. We work with CAH in Nebraska and/or their accounting firm or designee to attain and process all documents (files) required for the annual cost settlement.

Nebraska Total Care completes any required cost settlements in accordance with MLTC-issued cost reporting instructions and in accordance with all applicable requirements in effect at the time the cost settlement is required. We pay or collect the interim amount due from the hospital according to the amounts provided by MLTC based on its analysis of Medicaid hospital costs.

We use the same methodology as MLTC to reconcile settlement amounts with the hospital. Our calculations reflect the annual adjustment and applicable payment rates determined by MLTC as required by the available funds appropriated by the Nebraska Legislature.

We make any payments that may be required within 120 days after receiving all required documentation from the CAH desk reviews. If MLTC or Nebraska Total Care determines we made overpayments and payment is due by the hospital, we set up an invoice in accounts receivable and, if necessary, work with the provider to set up a payment plan. As necessary and based on information from MLTC, we update base rates and effective dates for impacted hospitals.

Complete and Accurate Reporting. Our reporting documents are subject to our standard quality control through a series of desk reviews. Assigned staff log all relevant documents and track completion and submission of all required reports to ensure compliance with all reporting timeframes. Our Director of Data Analytics reviews reports confirming reported costs are allowable and reasonable, and calculations of the final settlement are accurate. We ensure the accuracy and completion of all applicable fields. Nebraska Total Care designates our Accounting staff to serve as the primary point of contact for questions on the status of the annual CAH cost settlement.

> "We have been very pleased to work with Nebraska Total Care the last several years. Not only are they are advocates for their members, but they also great advocates for the providers in which their patients are being seen. Whenever we have a payment or claim issue, they are quick to respond to help us find a solution. All of their provider representatives, contract managers, and other staff we have been in contact with over the years have been excellent resources and deliver great customer service."
>
> *--Dayle Harlowe, Chief Revenue Officer – Executive Director Foundation, Fillmore County Hospital*

RFP 112209 O3

B. Technical Approach

V.R Systems and Technical Requirements

V.R Systems and Technical Requirements

98. Provide a general system description that details how each component of the Bidder's health information system will support the major functional areas of this contract. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements.
Describe how the Bidder's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the Bidder's systems. If modifications or updates are required, describe them and the Bidder's plan for completion prior to program operations.
Page Limit: 12 Not including the systems diagram

Integrated and Interoperable MIS Supporting Heritage Health

Reliable Partner

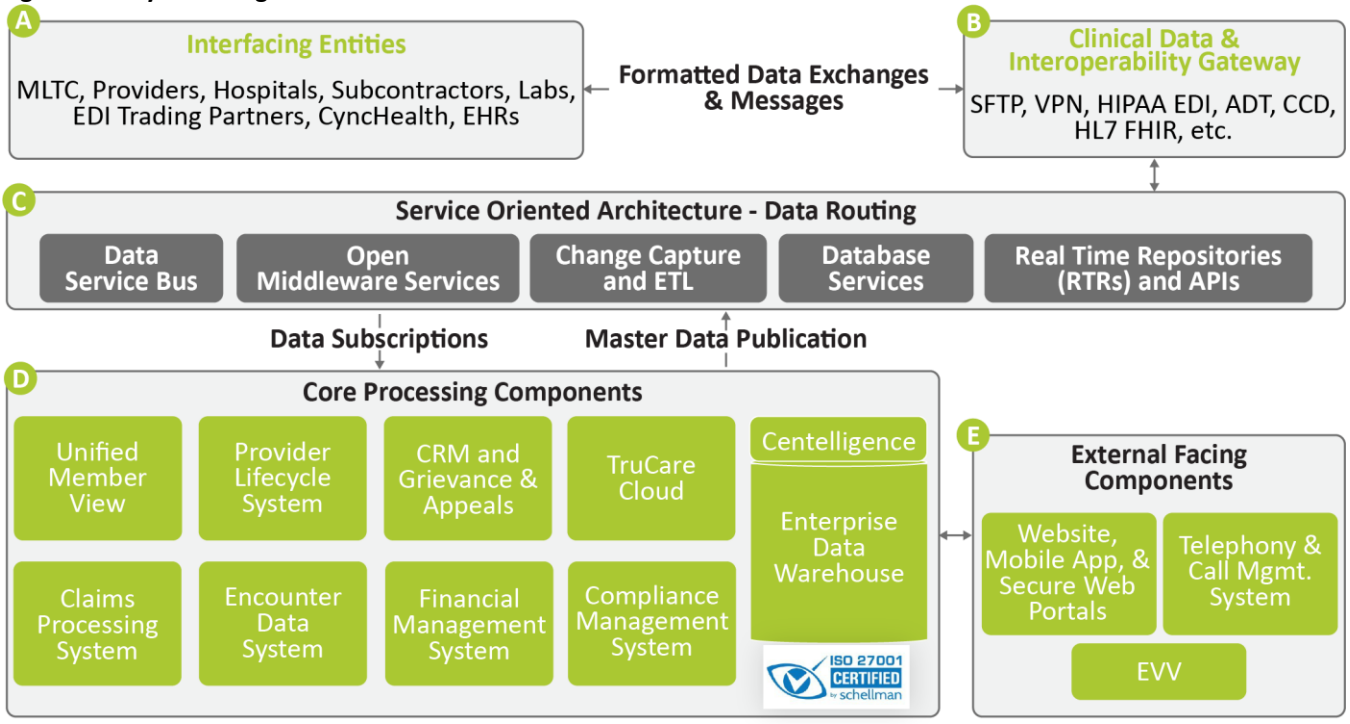
Our MIS complies with all requirements in Section V.R of the Scope of Work (SOW) and will not require any modifications prior to program operations.

Since 2017, Nebraska Total Care has been a committed local partner to Nebraska Medicaid stakeholders. Complete, accurate, and timely data is foundational to our commitment to compliance, and to be a transparent and accountable partner for Heritage Health. We use an integrated and interoperable Management Information System (MIS) provided by our parent company, Centene Corporation (Centene), that supports efficient physical and behavioral health (BH) administration on a unified platform equipped with capabilities that enable the delivery of high-quality health care. Across affiliate health plans, our MIS reliably supports over ***15 million Medicaid Members nationwide*** and processes ***300+ million encounter records*** annually, ***550,000 Admission, Discharge, and Transfer (ADT)*** transactions weekly, and ***137 million data queries*** every day. Our MIS is currently used to support our Nebraska Medicaid and HIDE SNP members and providers through claims and encounter data processing, reporting, analytics, and provider functions. Additionally, to ensure our MIS is secure, we use HIPAA-compliant controls as part of our ISO 27001 Certified Security Program such as facility monitoring, role-based access, audit trails, and encryption, and perform regular risk assessments.

Management Information System Components and Diagram

Our MIS includes several integrated core components that capture and provide information on all functional areas in alignment with **Section V.R.1 of the SOW**, including but not limited to, enrollment, eligibility, Provider Network Management, Care Management, claims processing, encounter submission, Financial Management, Grievance and Appeals, and Electronic Visit Verification (EVV). Please reference Figure 98.A below for our system diagram.

Figure 98.A System Diagram



Interfacing Entities (A)

Our MIS is equipped to collect, analyze, integrate, report, and manage data in partnership with MLTC to support the Nebraska Medicaid Managed Care Organization (MCO). Our MIS is designed for efficient data exchange and helps facilitate cross-system collaboration and coordination. We exchange data files with MLTC; Subcontractors (pharmacy, vision, and dental future-state in alignment with the new contract); network providers; other State, Federal, and local governmental agencies; and other sources using the industry-standard application, data, and communication interfaces. Our integrative approach demonstrates our commitment to developing and enabling streamlined processes for our partners. This in turn reduces duplication and improves the experience of members. Our MIS supports the transmission of data files through Secure File Transfer Protocols (SFTP), Application Programming Interfaces (APIs), and Virtual Private Network (VPN) connections. We use Public Key Infrastructure strategies, for example, SFTP for file exchanges for encryption, sender validation, and data integrity assurance. Our MIS design is informed by CMS' Medicaid Information Technology Architecture (MITA 3.0) with a standards-based Service-Oriented Architecture (SOA).

Clinical Data and Interoperability Gateway (B)

A critical success factor in the effective coordination and delivery of care for members is the appropriate and timely sharing of relevant information between and among health care entities across Nebraska. We believe that finding opportunities to share actionable information at the right time, with the right organizations, and within the right workflows leads to the greatest adoption of capabilities. To deliver information closer to the point of care, Nebraska Total Care supports clinical data exchange capabilities with providers, hospitals, MLTC, and the State Health Information Exchange (HIE), CyncHealth. Our investment in interoperability enables us to deliver information closer to the point of care to reduce the potential for providers and care teams to have to look in multiple places or enter data in multiple systems, reducing duplication and ensuring they have the data they need while caring for their members. We continue to enhance our data sharing capabilities, allowing us to go beyond support for all HIPAA transactions (please see Question 99 for further details), State proprietary formats, and NCPDP for pharmacy claims, as well as proprietary formats. We support interfaces to all major Electronic Data Interchange (EDI) claims clearinghouses and support direct submission of claims and other files through our secure Provider Portal as well as the Availity® Essentials Multi-Payer Portal, which is used by over 9,000 providers in Nebraska today. We also send large data files via SFTP to providers who can accept and process them. For subcontractor data transmissions, we support all standard interface data exchanges for expanded and meaningful use of industry best practices, and standards-based formats.

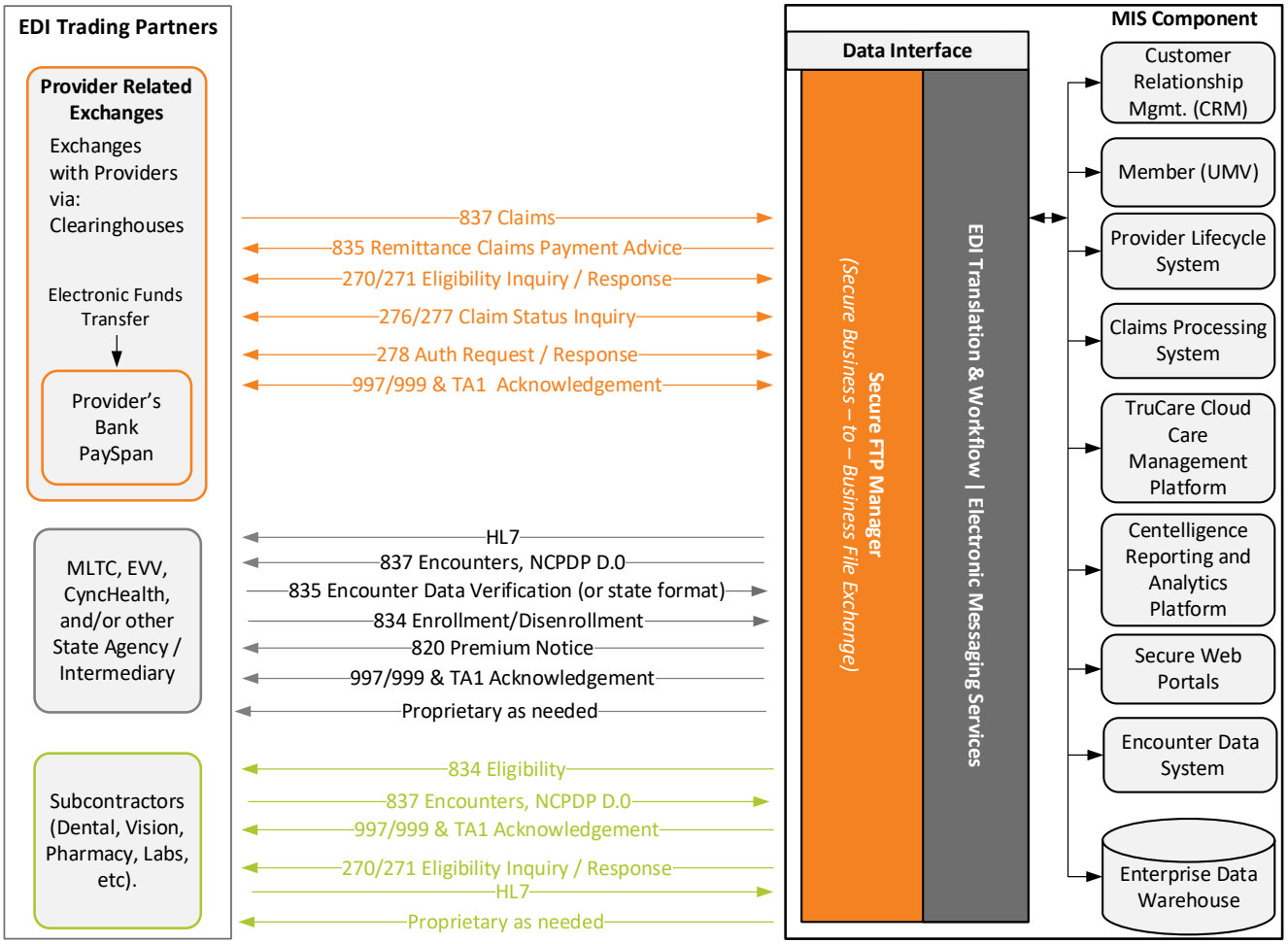
Industry Leading Partner. Nebraska Total Care and Centene continuously seek to employ the next generation of effective industry technology. For example, ***Centene is an active partner in the CARIN Alliance***, a non-partisan consortium of industry leaders, including health IT companies, working to overcome barriers to member-directed health information exchange across the United States. Through CARIN, we are collaborating on best practices for member support of app selections and security education, HL7 FHIR Implementation Guides for API implementation and support of USCDI, coordinated communication with ONC and CMS for guidance, and other activities of common interest to ensure industry compliance with the CURES Act.

Interoperability. Nebraska Total Care complies with the CMS Interoperability and Patient Access rules for Medicaid Managed Plans of Care set forth at CMS-9115-F. We are currently in production with the Patient Access and Provider Directory APIs and remain on target for production of Payer-to-Payer Data Exchanges aligning with CMS' dates for implementation. We are also ready to support the likely adoption by CMS of HL7's Da Vinci EHR-based prior authorization process. Our Clinical Data and Interoperability Gateway leverages RTRs for information exchange and centers on a scalable implementation of HL7 FHIR APIs. To deliver information closer to the point of care, our Clinical Data and Interoperability Gateway can interface with providers, hospitals, CyncHealth, MLTC, and other entities for standards-based data interchanges, including HL7 FHIR, ADT data, Consolidated-Clinical Document Architecture (C-CDA) exchanges, and other health information transactions. We will leverage our Clinical Data and Interoperability Gateway and strategic national partnerships to enhance our data sharing capabilities through bi-directional exchange with Provider EHR platforms. Expanded interoperability capabilities using FHIR, EHR proprietary APIs, HL7, and other standards allow us to automate the extraction of EHR data and deliver insights back into EHRs at the point of care. This bi-directional data exchange with alerts directly within the Provider's existing workflow will greatly improve efficiency and enable them to conduct targeted outreach for quality improvement.

File Exchanges. Through the Electronic Data Interchange (EDI) component of our MIS, we support all file receipt and transmission operations with MLTC, including our receipt of the daily and monthly HIPAA 834 enrollment and eligibility files,

the monthly proprietary Supplemental Enrollment File and Unborn File, the transmission of HIPAA 837 encounter reporting data, weekly provider files, and more. Our EDI subsystem protects file exchanges with access controls, authentication, and data integrity protections. We use EDI functional acknowledgments as a further control to assure delivery, data integrity, and record balancing. See **Figure 98.B Data Transmission Diagram** below.

Figure 98.B Data Transmission Diagram



Data Routing (C)

Process for Consuming Data. The Change Data Capture and RTR capabilities of our MIS integrate and consolidate the data we receive. We use best practices such as reference and metadata management, which ensure data is represented and stored accurately, completely, and uniquely, for example, eliminating data discrepancies or duplicates. Our approach to data management and governance ensures we have access to timely data that is understandable, clean, consistent, and reliable for reporting purposes. When data is loaded in our EDW, ELT processes routinely check for anomalies, data gaps, errors, and integrity across systems. Our EDW systematically receives, integrates, and transmits internal and external administrative and clinical data and supplies the data needed for all analytic and reporting applications while orchestrating data interactions between our subsystems. We employ microservices accessible via open APIs for a growing number of MIS functions to enable administrative efficiency for our partners as well as our staff. ***Across our enterprise MIS, we process 1.2 billion internal API calls per day via our Real-Time Repositories (RTRs)***, which are high-performance databases designed for conveying updated information between our integrated systems. We continuously seek new ways for the efficient, accurate, secure, and timely exchange of pertinent health information with our providers and community partners for meaningful purposes. Through our data interfaces, EDW, and electronic communication, we transmit and consume data, to support Care Coordination and the overall administration of the Heritage Health Program.

Process for Validating Data. Our MIS features EDIFECS software which validates data structure rules and syntax to ensure data complies with standard HIPAA transaction formats and companion guides. Our MIS features secure file transfer automation software, which handles data exchanges and protects file exchanges with access controls, authentication, and

data integrity protection. We use EDI functional acknowledgments as a further control for assured delivery, data integrity, and record balancing. We support the use of Public Key Infrastructure (PKI) security for both encryption and sender authentication, which ensures that data files are transmitted untampered to ensure we only transmit Protected Health Information (PHI) over HIPAA-compliant secure communications channels. To further monitor our file transfers between MLTC and other trading partners, we utilize our File Transfer Management Dashboard, which provides us with full end-to-end visibility into critical file transfers and allows us to fully manage our file transfer environment. Through the dashboard, we can drill down into file transfers for real-time visibility of job scheduling and success, enabling a more rapid response to EDI file transaction errors and delivery.

Routing Data Systematically and Efficiently. Our Centelligence Data Service Bus, a set of open middleware services implemented through standard transaction messaging services, APIs, and open database connectivity interfaces, electronically routes data to and from our integrated Core Processing System Components (See Figured 98.D). This ensures that data is made available for staff to perform required job functions. Data is loaded into our Centelligence Enterprise Data Warehouse (EDW) using standard extract, transform, and load (ETL) processes. All data produced internally as well as data captured from external sources are housed in the EDW, a key component of our MIS powered by high-performance Teradata technology. The EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, along with health assessment information, and authorizations. Housing all information in the EDW allows us to generate reports from a single data repository. Additionally, our MIS allows us to integrate claims data from subcontractors processing claims on our behalf, for example, pharmacy, dental, and vision benefit managers.

Reconciliation. We have designed reconciliation processes throughout our MIS to ensure all records match when coming in from external sources, updating across our MIS components, and going back out to entities such as MLTC, subcontractors, providers, etc. For example, we keep on record a copy of all files we receive along with a balance report that shows a confirmation that we received all expected records, and if there were any potential discrepancies.

Core Processing Components (D)

Unified Member View (UMV). We receive and load all eligibility data into UMV which serves as the source of truth in our MIS for all Member information, including MLTC historic files, other demographic and clinical data sets, and current and historic benefits. UMV employs a master data management approach to collecting, updating, matching, quality-assuring, storing, and distributing Member enrollment information we receive from MLTC to our MIS subsystems and our subcontractors MIS needing that information.

Claims Processing System. We use a premier Claims Processing System to support accurate claim adjudication for complex benefit plans and multiple provider reimbursement models. Our Claims Processing System supports medical and behavioral health (BH) processing, as well as Medicare Advantage administration, and for our Exchange family of individual insurance products, enabling a uniform approach to coordinated benefits administration. Together with our other integrated software, our Claims Processing System fully supports HIPAA standard EDI and Electronic Funds Transfer (EFT) capabilities, as well as detailed, real-time clinical edits and advanced Fraud Waste and Abuse detection. The EDI subsystem of our MIS uses EDIFECS software to verify HIPAA format compliance, validate inbound claims data against ASC X12N Companion Guides and rules for syntax and data structure, and trigger notification of claims failing these edits. Our middleware maps translate and validate claims against data records in UMV and Provider Lifecycle System before adjudication, ensuring the consistent application of common edits, such as Member billing and rendering provider identifiers. Once claims pass pre-adjudication edits, they are loaded into our Claims Processing System for adjudication through a combination of edits examining diagnosis and procedure codes including Health care Common Procedure Coding System (HCPCS) data, Medicaid National Correct Coding Initiative (NCCI) edits, and use and validation of National Provider Identifier (NPI), State Medicaid provider ID numbers, Tax ID numbers, and zip-codes for Provider payment.

Claims Submission. We have a no wrong door approach to claims submission, for example, EDI Batch File and Direct Data Entry (DDE) on our Provider Portal, Availity® Essentials Multi-Payer Portal, Clearinghouses, or Paper Claims, our secure Provider Portal allows Providers to request adjustments to claims, search for claim status, view and download payment history, and submit claims reconsiderations and view the status/outcome. Other claims management features include code Auditing software to model adjudication logic before submission and Claim Status Tracker with color-coded visualization of status (paid/denied/pended).

Edits. Upon receipt, our MIS translates claims data, performs an initial screening, and either rejects the claim or assigns a unique control number for further processing. This unique control number incorporates the Julian time stamp we affix to all claims upon receipt, allowing us to link together all information surrounding a claim and to track adherence to timeliness standards. Paper claims are processed with the same data validation edits as electronically submitted claims in appropriate HIPAA-compliant formats.

Corrections and Adjustments. If multiple claims need to be adjusted, for example, due to retroactive eligibility, our Claims Team initiates a claims project. Claims projects are assigned to appropriate Claim Staff to correct the issue, identify all impacted claims, and implement needed adjustments.

Timely Payment of Claims. Our integrated Claims Processing System ensures ongoing compliance with clean claim prompt payment requirements set forth by MLTC. ***Our performance has consistently exceeded QPP requirements in Section V.S of the SOW, which is demonstrated by our adjudication of over 98% of claims within 10 days and 99% of claims within 60 days***. We abide by the date of receipt and date of payment requirements specified in 42 CFR 447.45 and 447.46. We measure claim timeliness from the date we receive the claim to the payment date (paper check date or EFT notification date), or date of electronic or paper denial notice. As stated above, our Claims Processing System applies date and time stamps upon receipt of all claims (electronic or paper), enabling our system to retain a comprehensive audit history of all claim transactions and data elements including date span logic, historical claims tracking, and operator ID stamping, enabling us to filter down to a specific parameter for targeted audits. To help identify trends and patterns of non-payment, especially for providers new to Nebraska Total Care, once a month we conduct reviews of all adjudicated claims for denial patterns, such as by procedure, denial codes, and/or individual provider. We identify systematic trends and formulate appropriate solutions including provider education, individualized technical assistance, and system configuration enhancements.

Provider Payment and Remittance and Claims Denial. We have established payment cycles that occur two times a week to ensure timely payment to providers. As part of our payment process, we offer providers EFT and electronic remittance advice (ERA) payment options, as well as a paper check and Explanations of Payment (EOPs). Our ERAs/EOPs provide an itemized accounting of the individual claims in the payment including, but not limited to, the member's name, date of service, procedure code, service units, and amount of reimbursement. Today, a provider will receive an ERA or EOP even if a claim denies, clearly stating the reason(s) for denial, along with instructions for correction and resubmission, if applicable.

Encounter Data System (EDS). In partnership with our centralized Encounter Business Operations (EBO) team, we use our industry-leading encounters workflow system, EDS, to support the submission of over 3.8 million encounters annually to MLTC and all encounter operations. EDS edits claims data, creates encounter submissions files, loads inbound response files, and tracks and reports encounter data status. EDS' table-driven configuration functions allow us to implement encounter rules and edits to ensure encounters are HIPAA-compliant 837 transactions that meet **Section V.R.2 of the SOW**, content, format, and transmission specifications. EDS indicates claims payment status and claim type that is original, void, or replacement.

Encounter Accuracy, Completeness, and Timeliness. We employ multiple stages of systematic encounter editing and processing to ensure that submitted encounters are accurate based on X12 EDI and MLTC compliance edit requirements. EDS allows us to drill down to the detail claims service line level to rapidly examine and act on any encounter-related issues, as appropriate. We recognize that it is important to submit complete encounter data, including all paid and adjusted claims submitted by all network providers, subcontractors, and out-of-network providers reimbursed on an FFS or capitated basis. Our pre-delegation and annual re-assessment process for subcontractors, reviews and enforces policies and procedures specific to delegated encounter data activities. Our agreements with subcontractors and network providers outline our ability to enforce performance requirements if encounter submission service levels are not met for encounter data. Using dashboard analytics, we monitor encounter data performance metrics for each subcontractor, such as volumes and timeliness rates. We compare monthly financial data (from finalized claims) with corresponding accepted encounter submissions to ensure encounter data is not just being accepted, but also that what is being accepted is a complete representation of the services provided. Using this process, we account for every paid claim, verifying finalized claims processed as encounters, inclusive of all payment adjustments. Where discrepancies arise, we reconcile and resolve these issues to ensure all encounters are submitted to MLTC in an accurate, complete, and timely manner. We create and submit Encounter Data files for each claim payable run per MLTC's stated submission timeframe schedule. Our transaction manager software handles our automated, scheduled file exchanges with MLTC to ensure timely delivery and receipt of encounter submissions. To confirm successful transmission, we monitor EDI acknowledgments issued by MLTC upon each submission for Encounter Data. We submit encounter files for paid institutional, professional, and BH claims, as well as corrected encounter files, following MLTC's submission schedule. Additionally, we use the HIPAA-compliant NCPDP file for pharmacy transactions. Please see Question 99 for additional information on HIPAA standards and code set compliance. We currently submit weekly finalized encounter submission files

Timely Encounter Data

Since 2018, Nebraska Total Care encounter acceptance rates for physical health and pharmacy encounters combined annually exceed the QPP measures above the 98% threshold.

via SFTP to MLTC. We prepare capitated encounters for MLTC in the same manner as encounters produced from FFS claims and apply the same compliance and business rule edits (known as scrubs) to check these encounters before sending them to MLTC. These encounter submission controls ensure we submit complete and timely Encounter Data within 2 calendar days from the end of the adjudication cycle for that week or receipt of an encounter. Our encounter data includes all data as specified in the SOW including but not limited to utilization data for outpatient drugs, including National Drug Codes for each claim to support the Medicaid Drug Rebate Program.

Correction, Voiding, and Resubmission. If a previously paid claim, submitted as an encounter, requires correction, we will adjust the claim and resubmit the encounter as either a replacement or a voided encounter within the timeframe specified by the State in **Section V.S of the SOW**. Following the contract, we will address at least 90% of reported errors within 30 calendar days and 99% of reported errors within sixty 60 calendar days.

Provider Lifecycle System. Our Provider Lifecycle System supports all our core provider functions including prospecting, recruiting, contracting, credentialing, enrollment, data management, and ongoing engagement. Our Provider Data Management Team uploads enter, and updates provider data in our system, ensuring all Provider data comes from one governing source for complete data integrity. The system stores all unique provider identifiers including Tax IDs, National Provider ID (NPIs), Medicaid IDs, etc., and includes all demographic and location data, such as specialties, locations, office hours, phone numbers, accessibility, and capacity. The Provider Lifecycle System is integrated with our CRM platform, enabling enterprise-level call center support for provider inquiries, outbound campaigns and targeted outreach, and unified provider contact management and communications. The system is also integrated with our Claims Processing System to accurately process claims and pay providers. Our CEO, Heath Phillips, leads the MCO collaborative and will partner with MLTC and MCOs to implement a statewide Central Credentialing Verification Subcontractor (CCVS) to support providers in adoption, improving administrative simplification, and reducing duplicative data entry and processes upon implementation.

LexisNexis® Provider Data Validation Service. To ensure our provider data is of the highest quality and accuracy, we utilize LexisNexis, an industry-leading provider data validation service, which allows us to perform daily verifications. The service includes a Provider Data Intelligence Suite, which provides ongoing provider outreach, a secure web portal through which providers and practice managers can attest to provider information, and database matching services, leading to improved data quality in our provider files.

Quest Analytics. Through the Quest Analytics tool, we provide geo-mapping and network adequacy reports for Nebraska Total Care's Network Development and Contracting staff, and Google Map capabilities to assist Member Service Representatives (MSRs) and our Care Management teams in matching a member with the best provider to meet that member's needs.

Online Provider Directory. Our Provider Lifecycle System also powers our Find-a-Provider online Provider Directory available on our website, Member Portal, and MyNTC Member Mobile App. To help ensure members have access to updated provider information, including accessibility information, our Provider Relations and Provider Engagement Managers perform monthly roster reviews as well as directory, access, and availability outreach to ensure that provider information is accurately displayed.

Customer Relationship Management (CRM) and Grievance and Appeal System. Our CRM platform enables us to identify, engage, and serve our members, providers, and State partners in a holistic and coordinated fashion across the breadth of their wellness, clinical, administrative, and financial matters. Integrated with our MIS, CRM affords a 360-degree view of our relationship with members and providers for our MSRs and Provider Service Representatives. This integration helps eliminate inconsistencies and ensure that our staff has access to the information they need to support and assist members and providers. For example, MSRs can view a calling member's information across all historic and current Nebraska Total Care eligibility spans, view any care gaps, and assist members with their requests such as completing a health assessment or filing a grievance.

CRM provides an integrated approach to service management enabling our staff to resolve a majority of call inquiries in one call (first call resolution). Additionally, CRM helps facilitate and coordinate communication between our staff, our members, and providers (including support-a-user capability between MSRs and our secure web portals) and collect and update member and provider demographic data. CRM provides an integrated approach to service management including, but not limited to, the following capabilities:

- **Workflow and Automation Capabilities.** MSRs can route any inquiry-related task requiring follow-up to appropriate staff such as eligibility specialists, claims processors, and clinical staff while also enabling MSRs and their supervisors to manage all tasks to successful completion in the fastest possible timeframe. For example, according to Third Party Liability (TPL) and Coordination of Benefits (COB) policies, if a member shares with us TPL or COB information, the MSR collects that information in CRM, which automatically constructs a task for our COB Specialists to validate and update

member records contained in UMV. CRM also guides our staff through each step of a caller interaction, driven by the caller's interests and questions. Further, CRM features educational dialog for staff to inform members of pertinent health information, such as care gaps, as well as suggested tasks or 'next best actions' to initiate with the caller.

- **Inquiry Tracking.** All service interactions with a member or provider become part of that member or provider's online record and are tracked to enable unified communications (phone, e-mail, fax, mobile, web, and interactive messaging).
- **Complaints, Grievances, and Appeals Application.** This component of CRM captures, tracks, reports, and manages complaints, grievances, and appeals as well as reasons for disenrollment other than loss of eligibility. Please see Question V.B.4 for additional details on disenrollment.

TruCare Cloud. TruCare Cloud is our Member-centric platform for collaborative Care Management, utilization management, and population health for all Nebraska Total Care members and providers. Among other functions, TruCare Cloud houses the member's plan of care, which displays the member's identified health problems, treatment goals and objectives, interventions, outcomes, milestones, and completion dates. TruCare Cloud's integration with our EDW and Centelligence enables access to unified data from a variety of sources to allow our staff to profile, measure, and monitor members.

Holistic Member Dashboard. TruCare Cloud's interfaces and data integration points enable us to provide Care Managers with a holistic picture of our members' health, ultimately resulting in improved outcomes. Our TruCare Cloud Member Dashboard offers Care Managers access to actionable information about a Member including any open care gaps (such as PCP visit gaps, eye exam gaps, quality care gaps, disease management-related care gaps, and care gaps systematically identified through the Medical Necessity and Level of Care Assessment), a comprehensive timeline of a Member's clinical visit history, for example, outpatient visits/admissions, inpatient admissions, ambulatory services, and ER, PCP, or urgent care visits, as well as a log of all Nebraska Total Care correspondence, outreaches, and inbound calls with the Member. Additionally, external data sources are integrated to drive clinical interventions, inform our outreach efforts, and verify service delivery. For example, we receive ADT data (including details like visit type, facility name, and discharge disposition) through our connection to CyncHealth which is used to flag Members on a Care Manager's caseload for follow-up and discharge planning support.

Screening and Assessment Features. TruCare Cloud houses assessment and screening information for our members, including functional assessments, risk screenings such as the Nebraska Medicaid Health Risk Assessment (HRS) and the HIDE SNP Health Risk Screening (HRS), Health Needs Assessments such as the complex Care Management assessment, biometric screenings, SDOH mini screening, and depression screenings such as the Columbia screening. TruCare Cloud allows Care Managers to administer straightforward assessments and offers a library of effective interventions tailored to the member's needs.

Clinical Decision Support Tools. As approved by MLTC we integrate clinically accepted, evidence-informed clinical guidelines and decision support criteria, for example, InterQual Connect™.

Integrated Workflow Tools. TruCare Cloud's integrated workflow tools identify members needing care, track outcomes, and identify program/quality improvement initiatives. TruCare Cloud houses information on outreach efforts, and clinical appeals, and includes links to Care Management programs. The integrated data design of TruCare Cloud supports medical and BH prior authorizations, concurrent reviews, discharge planning, and transition service reviews.

Financial Management System. At the heart of our financial management suite of tools is our Enterprise Resource Planning tool, PeopleSoft, which records and reports financial administrative data related to the Medicaid program. All financial transactions are auditable per Generally Accepted Accounting Principles (GAAP) guidelines, and historical data can be obtained from PeopleSoft via online queries and reports. See the table below for additional capabilities.

Compliance Management System. We use our Compliance Management System to monitor our MLTC contractual and regulatory reporting and certification requirements.

Centelligence. Centelligence is our proprietary, comprehensive family of integrated decision tools that provide expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill-down capabilities (see **Figure 98.C** for additional details). Centelligence powers our provider clinical quality and cost reporting information products. Through Centelligence, we report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project (PIP) informatics, and other critical aspects of our operations. Centelligence includes a suite of best-of-breed predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at the population,

member, and provider levels. To ensure our predictive models are meeting established standards, we apply a rigorous and ongoing review process to verify the results are useful, accurate, and fair, and avoid reproducing social, economic, racial, and health disparities and related biases. Reviews are conducted by the Data Science Governance Committee, which is comprised of data science and analytics leaders, information technology leaders, and senior technical experts. The following models are a sampling of those that we leverage to understand and support the unique needs of the population:

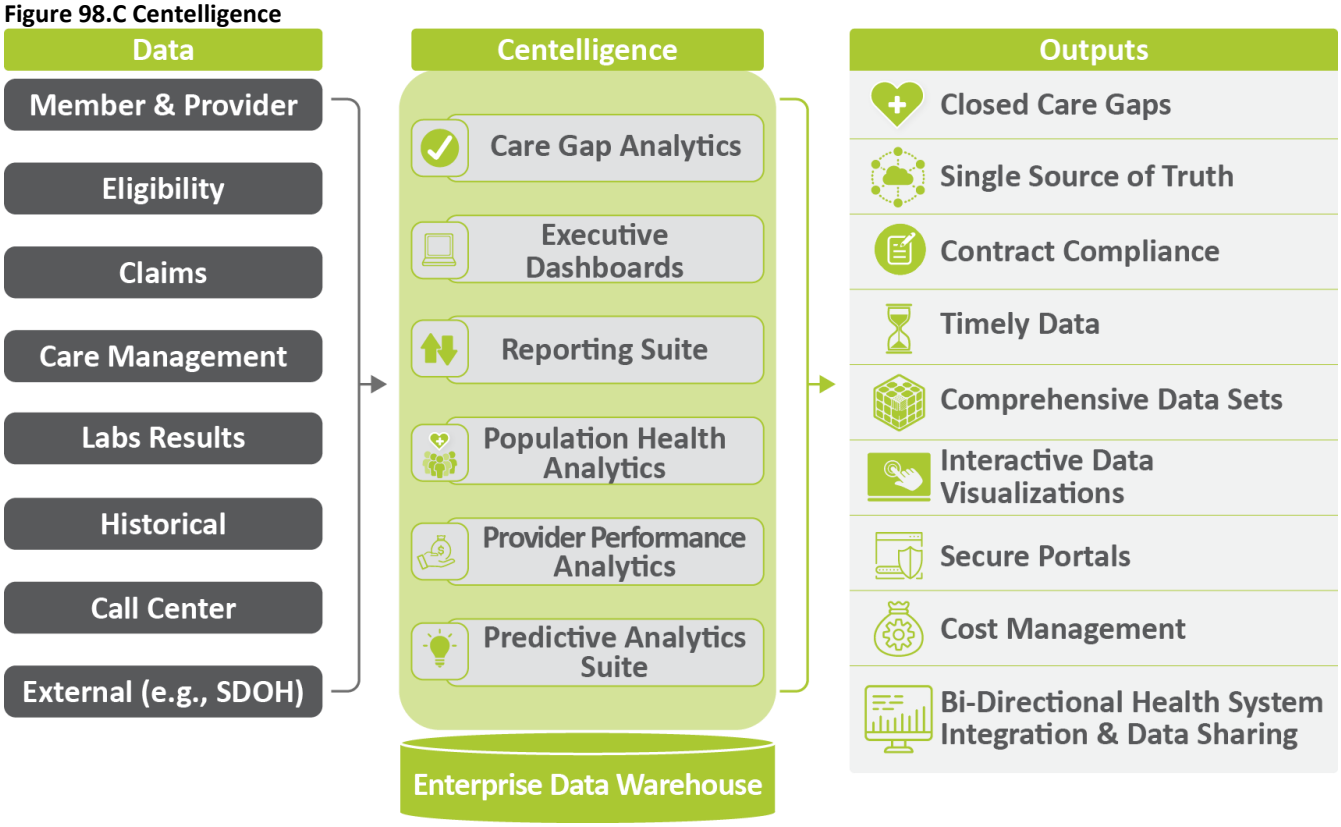
Tailor-Made Reporting Capabilities

To support Medicaid expansion, we successfully met 100% of the new reporting requirements within MLTC timeliness as validated by our readiness review.

- **Neighborhood, Economic, and Social Traits (NEST),** our predictive modeling algorithm, use member and public data sources to predict member-level risk attributed to social factors. Scores aggregate at geographic levels and heat maps are generated to identify leading SDOH indicators that correlate with poor health outcomes. This allows Nebraska Total Care to identify population health trends and areas of high need and tailor programs accordingly.
- **Health Disparities Reduction Model** analyzes disparities in health and utilization outcomes allowing our staff to tailor interventions across populations to address inequities in health care.
- **Start Smart for Your Baby Risk Model** applies machine learning for a vastly improved model that identifies pregnant members at elevated risk for delivering a high-risk baby. This tool risk stratifies our entire pregnant population, including members that have not submitted a pregnancy risk assessment. This model helps ensure we are accurately identifying our pregnant members and connecting them to needed pregnancy supports including our Start Smart for Your Baby program. We enhanced our model by including additional SDOH variables which have proven to increase performance across all model diagnostics, including sensitivity, specificity, and accuracy, enabling Care Managers to provide a range of perinatal interventions and supports targeted to each member's specific needs and level of risk.
- **The Behavioral Health Risk Model identifies members that may need BH Care Management thus informing our outreach and directing resources to members in need of BH supports.**

Additionally, Centelligence powers our ***Health Equity Dashboard***, which enables us to identify disparities in health outcomes due to race, ethnicity, language, and/or geography, and our ***SDOH KPI Dashboard***, which aggregates data from claims and assessments to analyze SDOH needs by cost, utilization, and demographics. Together, these tools help us identify needs, share disparity information with MLTC and other community partners, and design initiatives and programs at the member, provider, and community levels.

Figure 98.C Centelligence



Quality Tools. A component of Centelligence is our use of industry-leading quality tools. We have enhanced our quality program by improving our ability to deliver prospective care gap analytics capabilities to our staff. Our care gap information is re-computed and updated frequently to address member care gaps. These care gaps and health risk alerts are supplied to members and providers online, via our secure Member and Provider Portals, allowing our members and providers to securely access actionable health information. In TruCare Cloud, our Care Managers can view care gap data at the member, provider, and practice levels, with drill-down functionality for member-specific and clinical details. Care gap alerts are accompanied by clinical evidence, for example, relevant data and sources to help users understand how care gaps were operationalized, and easily close member care gaps within a single source. Our care gap capabilities are part of our overall strategy to use analytics to create a forward-looking health roadmap for our Nebraska members, to enable staff to identify and address emerging member health issues at the earliest, clinically appropriate time, before they become significant health conditions.

Enterprise Data Warehouse (EDW). The foundation of our Centelligence proprietary data integration and reporting strategy is a comprehensive EDW, powered by high-performance Teradata technology. Our EDW systematically receives, integrates, and transmits internal and external administrative and clinical data. EDW supplies the data needed for all of Centelligence's analytic and reporting applications while orchestrating data interfaces among our core applications. Housing all information in the Centelligence EDW allows staff to generate standard and ad hoc reports from a single data repository.

Ad Hoc Reports. Centelligence offers a library of report templates that staff can draw from to produce reports. Additionally, our Report Builder offers an intuitive interface for ad hoc reporting requiring limited to no coding knowledge.

External Facing Components (E)

Nebraska Total Care Website. Our publicly available, mobile-responsive website, contains member and provider resources and provides current and accurate information about our programs, including but not limited to eligibility requirements, program sign-up instructions, benefits information, the grievance system, and services we provide.

Member Portal. Our secure, web-based Member Portal is fully mobile-optimized, informed by human-centered design, and offers members online access to their Nebraska Total Care information and many self-service functions, such as the ability to:

- View clinical service and medication history
- View, print, and download a digital version of their ID Card
- Submit a member grievance or appeal
- View, change, or search for a primary care provider
- Update contact information, login information, and manage dependents' health information
- Take an online health needs assessment
- View a health alert, gap-in-care, or member-centric plan of care
- Communicate with Nebraska Total Care staff, including assigned Care Managers
- View their clinical service and medication history, as well as access their Explanation of Benefits (EOB)
- Access contact information for our 24-hour Nurse Advice Line
- View authorizations, including authorization status
- Access community resources through a direct link to Findhelp

Members can also check the status of their My Health Pays® rewards incentive balance. Our My Health Pays program actively promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors and adherence to their plan of care regimens.

Provider Portal. Our secure Provider Portal is a web-based platform supporting PH and BH provider administrative self-service capabilities including eligibility inquiry, authorization submission, and status, claim submission, claim status, claim payment history, and a growing number of clinical applications. These clinical applications include:

- Online care gap and health alert notifications
- Emergency Department high utilizer flag (if a member has had three or more emergency department (ED) visits in 90 days)
- Member Health Record (delivering advanced capabilities for clinical Care Management)
- Patient Analytics for population health
- Provider Analytics for provider performance management (see additional information and **Figure 98.D** below)
- Care and disease management referral
- Practice-level clinical quality and cost reports
- Clinical practice guidelines

Provider Analytics. Powered by Centelligence and available to providers through our secure Provider Portal, Provider Analytics brings together a collection of actionable and timely clinical and administrative data. Provider Analytics helps our staff and providers identify and prioritize member prioritization based on clinical needs and opportunities and understand the next best action to improve population health, for example, patient outreach, patient education, Care Coordination, etc. Provider Analytics is designed to foster partnerships between our staff and providers to enable effective cost management and quality improvement activities while optimizing providers' performance in pay-for-performance, shared saving, and risk contracts, when applicable. From the cost, utilization, and quality measures to value-based and member engagement, Provider Analytics delivers data that providers can interact with via custom selection, drill-down, and data exporting and reporting capabilities, to identify factors behind clinical and cost performance, and strategically target clinical actions. Data visualizations also make information accessible and easily digestible for users.

Secure Community Partner Portal. The secure Community Partner Portal is for authorized users in the member's care team to bi-directionally share and access key member and provider demographic and clinical information. The portal promotes information sharing and collaboration across providers and other partnering agencies while maintaining the security and privacy of members' protected information. Users can view member eligibility status, care gaps, health record data, for example, immunizations, allergies, labs, other insurance information, and plan of care, and can upload key documentation, member assessments, and free text and structured notes.

Telephony. Our telephony platform, along with our call manager system software, provides automatic call distribution (ACD) across our Member call queues and enables seamless and efficient call answering, monitoring, and reporting capabilities. Our call manager system software tracks and reports information processed through the ACD, enabling seamless and efficient call answering, monitoring, and reporting capabilities. We are enhancing our Telephony Solution with Amazon Connect to provide a more seamless experience for our Members and Providers. Amazon Connect will provide enhanced tools for our Call Center, including skills-based routing to our MSRs, real-time and historical analytics, and intuitive management tools.

Computer Telephone Integration (CTI). Fully integrated with CRM, CTI automatically matches the inbound calling number (based on a member's phone number) with the member's record (call history, demographics, care gaps, etc.) and populates

the record on the MSR desktop screen.

Electronic Visit Verification (EVV) System for Home Health Care Services. Our MIS supports the use of any EVV system adhering to HIPAA-based standards for claims transaction formats (837), and Federal and State standards for security safeguards, data integrity controls, claims matching, and audit transparency to enable bidirectional sharing of information and data in alignment with Section V.Z of the SOW. Through Centene, Nebraska Total Care brings extensive national experience with EVV utilization from affiliate Medicaid plans, and we will continue to support the State in moving forward with EVV adoption. Please see Question V.Z.113 for additional details on our EVV approach.

Management Information System Monitoring

System Performance and Availability. We monitor system performance through the use of automated, continuous monitoring systems. We are immediately notified if systems such as our claims processing, Care Management, or reporting systems drop below service level agreement thresholds, or if there are issues that may jeopardize system performance. Centene uses event monitoring architecture technology to support Nebraska Total Care and help ensure system availability and reliability in alignment with Section V.R. 10 of the SOW. Our technology includes system monitors, incident management tools, and online dashboards from leading suppliers that monitor subsystems, applications, data and voice network, capacity, and end-user experience. This combination of technology along with our Agile change management process provides us with the resources necessary for successful system modifications and changes in alignment with Section V.R.3 of the SOW. See Question V.R.100 for additional details on systems availability.

Policies and Procedures. As part of our adherence to Information Technology Infrastructure Library (ITIL) standards, we ensure that our system documentation is current, accurately describes systems operation, IT services, and processes, and is inclusive of the most current system changes. We also use our Compliance Management System workflow-enabled Systems Policy and Procedure (SPP) formulation (with a history of documentation and sign-offs), to ensure we have System Policy and Procedures for our MIS processes.

Systems Refresh Plan. We maintain the best practices approach to our Annual Technology Refresh Process, informed by continual capacity monitoring and forecasting, vendor release status, and business needs, which includes the formal publication of a refresh plan each year. We submit a copy of our Annual Systems Refresh Plan annually, which ensures that all of our software is maintained at current and tested versions, and meets requirements per Section V.R.1.4 of the SOW.

Change Management and Testing

Our MIS currently meets all contract requirements detailed in the SOW and we do not anticipate any changes before implementation. However, in the case upgrades are necessary, Nebraska Total Care's systems are specifically designed to nimbly respond to changing expectations surrounding our programs and technology. We introduce system changes using the Scaled Agile Framework (SAFe) approach, ensuring quality-control processes are in place to prioritize and implement changes efficiently. We use the Jira project communication system, as well as the ITIL framework, to power our collaborative SAFe change management approach. ServiceNow, an ITIL-based workflow application for integrating multiple aspects of MIS service delivery, helps ensure IT change processes are effectively managed and communicated in an auditable manner, whether internally initiated, requested by MLTC, or otherwise mandated including during the term of the contract. All system changes or upgrades include a plan detailing the timeline, milestones, and testing to be completed before implementation.

Change Process. We use a workflow-enabled change promotion process that begins with iterative development, unit testing, integration testing, and User Acceptance Testing (UAT) to assure changes are accurate through full regression testing to determine how changes in one system component impact other components. All system changes are controlled by our Change Review Board (CRB) and we orchestrate all changes through our ServiceNow change workflow platform, with a detailed and auditable record of changes. The CRB is our change governance body which serves as the prime gateway of a system change from development and test, and into production. The CRB consists of a blend of IT operations professionals and managers from application, hardware, subsystem, security, and data communications areas. From a software control perspective, our version control system offers us a system-inherent mechanism for recording any change to a software module or subsystem.

Communicating System Changes. For any system changes the CRB will ensure that we have an appropriate communications plan, both for internal and external stakeholders (including MLTC), implemented for the change. We will continue to provide MLTC prior notice of any major upgrades, modifications, or application updates in our core systems (claims, eligibility/enrollment, service authorization, provider data management) or conversions a minimum of 90 calendar days before such a change.

Internal System Enhancements. We apply routine system maintenance and capacity updates that are planned and introduced before performance issues arise. We weigh three considerations in prioritizing system changes: beneficial

impact on service operations; modification size (level of effort), complexity; and regulatory and contractual compliance, for example, a state mandate. We prioritize required compliance changes and those of high beneficial impact. Once a change is approved, we use a change promotion process orchestrated through ServiceNow to track configuration, testing, and deployment.

Testing Methodology. Supported by our parent company, Centene, we utilize a multi-level approach to our testing methodology. Our comprehensive testing approach features four key focus areas:

- **Shift Left.** Our first principle is identifying and planning key test data needs, focus areas, and needed artifacts early in the lifecycle, shifting left to enable faster development and testing phases.
- **Automation and Functional Expertise.** We look upon experience and best practices to focus on automating critical, high-frequency usage and defect-prone functionalities to build robust automated testing validations for faster turnaround.
- **High-Quality Test Data.** We leverage a self-service test data management framework with built-in data masking to procure production-quality test data and build high-frequency workflows to expedite test needs.
- **Self-Service Capabilities.** Focusing on self-service better enables development teams to make the needed progress. We provide our staff access to test data management, performance engineering, and automated scenario services.

These best practice processes for the development, testing, and promotion of system changes and maintenance allow us to adapt to any new technical requirements established by the State.

Master Test Plan. Nebraska Total Care and Centene maintain a Master Test Plan for all lines of business detailing the software testing performed during the development process to assess the quality of the software product. Software testing is completed by our IT Quality Assurance team, developers, and other stakeholders. Testing is completed iteratively in a rapid cycle fashion with development and configuration changes to ensure that desired functionality works accurately and as expected based on change requirements. All of our test plans and scenarios outline the strategy (including dates and participants), test cases, requirements, data input, expected output, results, and secondary validation associated with the testing. This process requires peer review by our software development professionals to ensure consistency with ITIL-based principles of software design and security compliance. All test cases, defects, and testing results are tracked in qTest and Jira, best-of-breed project communication and issues workflow systems, to ensure all critical defects found are re-tested and closed. Progress is tracked in ServiceNow, which includes an auditable record of changes and approvals.

MLTC Testing Initiatives. We work with the MLTC on any testing initiatives required by MLTC including for implementation and readiness and will provide sufficient system access to allow appropriate MLTC staff to participate in the testing. Nebraska Total Care will also provide a concierge service for MLTC to demonstrate any live system capabilities or recent changes, in-person (at MLTC or Nebraska Total Care offices) or virtually (via web conference session) to provide reasonable and adequate views into any systems used to support our services provided to the members and providers in Nebraska today.

99. Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange and ensure adequate system access management and information accessibility. Affirm the Bidder's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the Bidder's internal membership records, including differences in members' addresses.
Page Limit: 3

Proven Experience Supporting Federal Standards

Nebraska Total Care administers the Division of Medicaid and Long Term Care's (MLTC) Heritage Health program in full compliance with HIPAA and other Federal and Nebraska information exchange standards, on an enterprise-scale Management Information System (MIS) operated by our parent company, Centene Corporation (Centene). We leverage a variety of policies and procedures that outline our commitment and approach to supporting Federal standards and have been compliant with HIPAA on or before the effective dates of each HIPAA rule, including all applicable privacy, security, file, and transaction standard regulations from the original HIPAA legislation, as well as all subsequent regulations including the Health Information for Economic and Clinical Health Act (HITECH). We comply with the CMS Interoperability and Patient Access rules for Medicaid Managed Care Plans set forth at CMS-9115-F including making data available via FHIR, SMART/OAuth 2, and Open ID Connect using US Core Data for Interoperability standards (USCDI). We are currently in production with the Patient Access and Provider Directory APIs via our standards-based IT architecture, and our parent Centene participates in HL7 initiatives preparing us for future Federal IT requirements. We remain on target for the production of Payer-to-Payer Data Exchanges aligning with CMS' dates for implementation and we are ready to support the likely adoption by CMS of HL7's EHR-based prior authorization process.

Advancing Interoperability

We are the only Nebraska Medicaid MCO with a staff member, Aimee Black, serving on the Health Information Technology board to support the advancement of interoperability in Nebraska.

Our Clinical Data and Interoperability Gateway leverages Real-Time data repositories (RTRs) for information exchange and centers on a scalable implementation of HL7 Fast Health Care Interoperability Resources (FHIR) APIs. To deliver information closer to the point of care, our Clinical Data and Interoperability Gateway interfaces with Providers, hospitals, CyncHealth, and the State, and supports standards-based data interchanges, including HL7 FHIR, ADT data, Consolidated-Clinical Document (C-CDA) exchanges, and other health information transactions. Through our continuously updated and regularly audited HIPPA Privacy and Security Program, we employ an array of administrative, technical, and physical controls to ensure that information exchanges with our constituents (including MLTC and MLTC intermediaries) follow all HIPAA standards. Please see Question V.R 102 for more information on the scope and governance of our HIPAA Privacy and Security Program.

Information Security and Access Management

Through a blend of administrative, technical, and physical controls, our Access Management Program helps assure that all user systems' access to our systems and information is appropriate and follows the HIPAA Minimum Necessary Requirement for information accessibility, as well as 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records). Our HIPAA-compliant Business Continuity Plan and highly available IT architecture help us ensure that we maintain the highest possible level of information available so that all authorized users of our MIS can access the information.

Role-Based Access Control. We implement Role-Based Access Control (RBAC) for all applications that process electronic personal health information. RBAC addresses security risks by defining employee access rights based on the employee's job responsibilities, including whether that employee has access rights to update information or view only. For all applications, individuals responsible for granting access do not themselves have the rights to perform transactions within those applications; for example, the security administrator who

manages login profiles to our claims system cannot himself process claims. Individual security change requests are recorded through a documented security authorization and implementation process.

Auditing Systems Access and Usage. Our IT administrators check system log files to help identify any unauthorized login attempts. We record the regular certification by our managers of appropriate subordinate access to systems and our IT Security staff use software for Data Loss Prevention (DLP) and audit the appropriate use by personnel of systems, email, and the Internet. In the event sensitive compliance or privacy information is detected within email communications, our DLP process is to quarantine the email until our Compliance Team(s) can review the quarantined email to approve or deny release based on an assessment of sensitive information within the email content. Access to critical applications, databases, and operating systems is reviewed by system owners periodically to ensure that employees have access to the resources they need for their jobs.

Controlling Access through Physical Safeguards. As is the case with Nebraska Total Care's office, each data center is secured via proximity card access on all external doors, elevators, and the internal entry doors on each floor. Security guards at our datacenters require that all visitors are cleared for entry in advance of their visit, sign in and out at the front desk, utilize a temporary badge, and are accompanied by an employee when visiting. We also use digital security cameras and panic switches installed at each reception desk. Our card key system records all access attempts/card swipes whether successful or not.

Additional Security Safeguards Ensure HIPAA Compliant Systems Access. In addition to the above, we comply with HIPAA's Security Rule and other Federal standards via a comprehensive set of administrative, physical, and technical safeguards that ensure information is accessible to qualified users and information exchange partners. Please see Question V.R 102 for details.

Security in a Remote Environment

When Nebraska Total Care's workforce began working remotely during COVID-19, Centene provided resources via the Centene Secure Program detailing security best practices in working from home, including utilizing multi-factor authentication for logging in, keeping a secure office by continuing to lock laptop when not in use, utilizing a privacy screen, as well using a headset, or working in a private space to ensure calls are not overheard.

Resilient Architecture for Information Accessibility

Our network backbone is highly redundant through a mesh design that provides multiple paths to and from each point, allowing maximum network availability. This highly available architecture allows us to meet contract file exchange schedules so that information is accessible to MLTC as required. Additionally, this resilient design ensures that all authorized users including members, providers, and care team members can access systems and information necessary to improve the health of our communities.

Highly Available Systems. To mitigate the impact of any potential service disruption and avoid loss of data, Centene owns and operates three geographically separated enterprise data centers where all of Nebraska Total Care's core application data is housed, providing a redundant network.

HIPAA Compliance and Transaction Standard Support

We support all current Federally and State mandated HIPAA Version 5010 transaction formats, please see **Table 99.A** below for further details:

Table 99.A HIPAA Standards and Code Set Compliance
Enrollment/Eligibility: We use **HIPAA 834** for receiving daily and monthly eligibility and enrollment data support receipt and processing of these files from MLTC. Additionally, we ingest the non-834 data from the Supplemental Enrollment File both daily and monthly.
Premium Payments Remittance Advice: We support the use of the **HIPAA 820** and will process this file from MLTC per SOW.
Enrollment Verification: We use the **HIPAA 270/271** and will support it per SOW.
Authorization Request: We use HIPAA 278 and will support it per SOW.
Claim Status Inquiry and Response: We use the **HIPAA 276/277**, and we also currently support the use of the 277CA transaction as required by MLTC for encounter data processing.
Claims: We use the **HIPAA 837**, and via our PBM, we use the HIPAA-compliant version of the **NCPDP** pharmacy transaction.
Remittance Advice: We generate **HIPAA 835** transactions for electronic remittance advice.

We support all HIPAA 5010 code sets, including CPT and HCPCS procedure codes, ICD diagnostic and procedure codes, Explanation of Payment Remark Codes, Claim Payment Adjustment Codes, CORE CAQH Operating rules, etc. See Question V.R. 98 for additional details on our support of Electronic Document Interchange (EDI).

Resolving Discrepancies

Systematic Reconciliation. Through data exchanges with MLTC, we electronically receive and process enrollment records through ASC X12N 834 Benefit Enrollment and Maintenance transactions as well as supplemental enrollment files. We systematically retrieve and load enrollment files into our integrated EDIFECS EDI middleware, which validates and maps data in the enrollment files to the membership input format of our MIS. Our eligibility pre-processing software then edits for duplicate Member records, date criteria validity, field data integrity, and valid date spans, and then loads passing records into the master member files of our Unified Member View (UMV) system. We perform ongoing reconciliations as we receive 834 supplemental enrollment files to cross-check and resolve any differences in eligibility changes reflected in daily files received in the week and our internal records. All retroactivity and future enrollments are maintained within UMV, which acts as the single source of truth for all informational aspects of our member's relationship with Nebraska Total Care. Any member record that fails edit checks is not loaded and defaults into an exception report where staff systematically conduct data correction activities. Our eligibility pre-processing software then edits for duplicate Member records, date criteria validity, field data integrity, and valid date spans, and then loads passing records into the master member files of UMV. We notify MLTC's Information Support mailbox of any data inconsistencies for those records that are flagged as having a discrepancy, for example, identifying elements that may misalign between the eligibility files and our internal membership records.

Monitoring Monthly Capitation Records

Monthly Reconciliation. Each month, our MIS imports and processes an ASC X12N 820 file from MLTC. Our MIS reconciles the premium remittance detail from the 820 files against Nebraska Total Care member eligibility and enrollment records. UMV then uses a snapshot view of our membership to compare all the member-level premium payments in the 820 files to the premiums we expect to receive from Nebraska Total Care via a Monthly Remittance Reconciliation Process.

Capitation and Reconciliation Process. Our MIS produces a Capitation Reconciliation Report, which contains the number of members and payments matched correctly, as well as a listing of all the members not matched between the 820 files and 834 files. Our MIS also creates a Dual Members Report, which contains Nebraska Total Care members who have been retroactively assigned Medicare coverage, and a Recouped Members Report, which show members who have been voided by the State's Fiscal Agent. The Enrollment Team is responsible for validating member eligibility and any discrepancies that cannot be resolved internally at Nebraska Total Care and submits these irreconcilable discrepancies to MLTC and the State's Fiscal Agent.

Systems to Support Address Validation

The open architecture of UMV, allows us to leverage electronic integration with industry-standard address validation and address enhancement services, further enhancing the quality of member data we house and analyze.

Reconciling Member Identifiers. Connected to UMV, our Customer Relationship Management (CRM) is equipped to store multiple-member identifiers including the member's Medicaid ID number and our master person identifier (MPI) number. The MPI systematically links the member's Medicaid ID number as well as other identifiers, for example, Social Security Number, to identify each member across all of the systems and populations under our span of control. Storing multiple-member identifiers enhances our ability to maintain historic member data and results in a unified view of a member's enrollment history.

Processes to Support Validation of Member Contact Information. Nebraska Total Care staff and vendors utilize the Coding Accuracy Support System and the National Change of Address registry to recognize potentially inaccurate member addresses and to make sure we have the most current address for members on file. Quarterly we send e-mails and texts to members whose address or phone number is missing and direct them to update their information with the State, as the MLTC file remains our source of truth. In the case a member or provider calls in to correct or update their address or contact information, our Member Service Representatives are trained to record that updated information in alternate contact data fields in the member's online record in our CRM system. Additionally, we notify MLTC via iServe Nebraska, of these changes including changes in contact information or living arrangements for families or individual members within 5 business days of identification, as well as changes in mailing address, residential address, email address, and telephone number, in a manner and format required by MLTC. This approach allows us to capture the information without overwriting any member contact information we receive from MLTC via the HIPAA 834 daily or monthly eligibility and enrollment files. At no time do we edit address information sent to us from MLTC.

100. Describe the Bidder's approach to monitoring system availability issues and the resolution process. Provide a description of the Bidder's system help desk. Include the Bidder's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to Bidder management within one business day of recognition and are promptly corrected.

Page Limit: 2

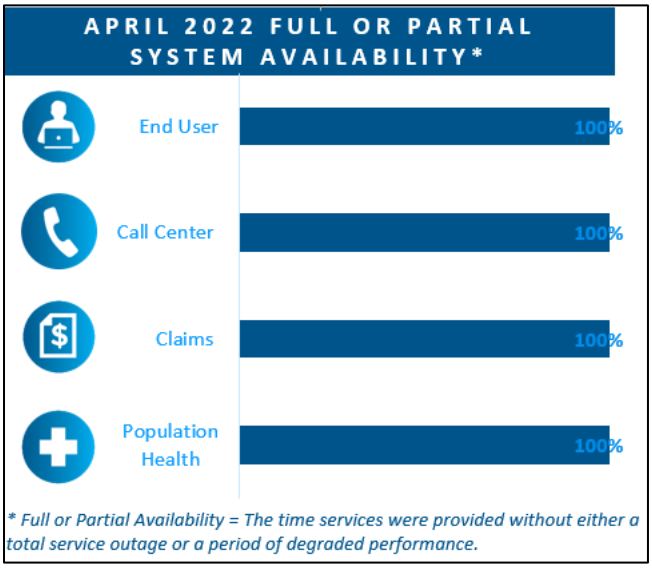
Management Information System (MIS) Engineered for Availability

Nebraska Total Care's Management Information System (MIS), supplied and operated by our parent company, Centene Corporation (Centene), supports more than 120,000 Medicaid members statewide, HIDE SNP members in 37 Nebraska counties, and over 15 million Medicaid members nationwide. We have intentionally engineered our hardware, software, and processes in our MIS to ensure high availability of our applications, appropriate partitioning, systems monitoring, and prioritization to ensure systems are available to members, providers, and our staff, and issues are resolved timely. We can mitigate, identify, and address availability issues through layers of system redundancy, Event Monitoring Architecture (EMA), and online dashboards to assess system performance in real-time. ***Centene owns and operates three geographically separated data centers where all core application data is housed for heightened resiliency.*** A fully redundant wide area network (WAN) connects the data centers to ensure an outage will not impact service delivery. Our approach is also coordinated with our Contingency Plan (Business Continuity and Disaster Recovery Plans), so that system availability threats outside our span of control are mitigated and addressed rapidly (see our response to B.Q103). Our systems and process-based approach to availability and incident management and resolution will allow us to meet all requirements in Scope of Work (SOW) Sections V.R.3 and V.R.10. For instance, all critical member and provider Internet or telephone-based functions and information will be available at any time (excluding scheduled maintenance and events outside our control) and cumulative system unavailability within our control will not be below 99.9% during any continuous 20 business day period.

Monitoring System Availability and Performance

To ensure continuous system availability, we use automated monitoring systems, IT service management applications, and online dashboards to assess system performance and capacity. This EMA technology runs on our applications and web servers to offer visibility into complex transactions for system performance monitoring. Our centralized Incident Response Operations Center (IROC) is made up of systems analysts, engineers, and management staff who will continuously monitor all systems, for example, websites, Member and Provider Portals, Centelligence Reporting and Analytics Platform, Claims Processing System for performance, service availability, and capacity utilization to anticipate and address situations before problems arise. IROC is immediately notified if any systems drop below service level agreement thresholds or if any issues may jeopardize system availability or performance. For example, our Performance Dashboard displays system availability and average response times in real-time for IROC monitoring. Nebraska Total Care leadership receives monthly scorecards (**Figure 100.A System Health Scorecard Sample**) which summarize these system availability metrics and service level trends to assess performance and target improvements where needed.

Figure 100.A System Health Scorecard Sample



Ensuring Capacity to Maintain System Performance. Our centralized Capacity Solutions Team monitors system metrics, for example, Central Processing Unit load, disk input/output (I/O), and network bandwidth crucial to maintaining satisfactory MIS and claims processing service and performance levels. The Capacity Solutions Team ensures that MIS resources are scheduled to provide a consistent level of service for current and future business needs. We use MIS capacity measurement tools from industry-leading companies to capture performance data, maintain a repository of that data for trending, analyze the data to determine accurately existing capacity, and equip our IT Management with an online capacity dashboard for monitoring. This data also aids in capacity planning, performance measurement, and service level reporting activities, and ensures MIS resources are scheduled to provide a consistent level of service for current and future business needs.

Issue Identification and Resolution

When IROC becomes aware of a system failure or interruption (from monitoring described above, reports from technical teams, reports from end-users to the Contract Compliance Officer and/or Nebraska Total Care leadership, or Systems Help Desk (SHD) incident reports), IROC will immediately invoke and coordinate response and restoration procedures and activate a temporary virtual command center with a pre-designated incident management team, inclusive of Nebraska Total Care leadership as well as Site Reliability Engineers, to ensure essential business functions are recovered and restored. IROC facilitates the resolution process by assembling the needed IT teams, tracking issue handling progress, and leveraging structured communications plans to provide ongoing status updates on issue resolution to critical IT and leadership staff. IROC also conducts root cause analysis and develops corrective action plans if needed to ensure issues are avoided in the future. Our IT processes enable us to resolve unscheduled system unavailability within our control and restore enrollment and claims management services within 60 minutes of determining the unavailability, and within eight hours for all other functions. Our Contract Compliance Officer will notify MLTC of any system outages or degradation that impacts MLTC customers, report distribution, or operations within 15 minutes of its discovery, and will provide hourly email or telephonic updates on unavailability events and problems resolution.

Systems Help Desk (SHD)

Our fully staffed SHD offers Monday through Friday support to Nebraska Total Care staff via phone and online chat from 7:00 am to 7:00 pm, central time. The SHD can perform all functions as required in SOW Section V.R.3.a through a local, toll-free number. Calls placed during off-hours have the option to leave a message, which our SHD responds to by noon central time the following business day. Our integrated IT service management tracking system affords SHD staff an automated method to record, track, and report on all questions and/or problems reported via the SHD to ensure deficiencies are promptly corrected. The SHD assists IROC in communicating incidents to Nebraska Total Care staff based on the severity (SEV) incident level:

- SEV 1: Extremely serious incident, such as a significant network problem or loss of service for a production application
- SEV 2: Incident involving loss of service for portions of an application, or a specific group of users is impacted
- SEV 3: Incidents where application functionality or data is impacted, but users can do their jobs and workarounds can be used, for example, an issue that isn't impacting business processes or end-users, interruption of service to a single user
- SEV 4: Interruptions caused by scheduled outage or event such as a security request, access request, backup request, or how-to questions

Identifying and Reporting Recurring Problems

Once an issue is resolved and services are restored, our Problem Management team documents the root cause and solution in our IT service management system to eliminate such issues in the future and inform future issue analysis and troubleshooting. And as noted above, our SHD also uses this IT service management system to report on all questions and/or problems they encounter, including those not specific to system unavailability, creating an ongoing record of recurring problems to reference. The system's ability to index issues using multiple criteria, in conjunction with its database design, enables us to quickly identify recurring problems and report them to Nebraska Total Care management within one business day of recognition so any deficiencies can be promptly corrected. We are also able to review EMA reports to prevent incidents from reoccurring. To ensure a closed-loop, our Contract Compliance Officer also coordinates notification to MLTC about the resolution of recurring problems. Nebraska Total Care will also provide concierge services for MLTC to demonstrate any live system in-person (at MLTC or Nebraska Total Care offices) or virtually (via web conference session) to provide further assurance that the issue has been resolved and that the system is performing as intended.

101. Provide a description of the Bidder's eligibility and enrollment database. Include a description of how the Bidder will:
• Complete updates within the timeframes specified in the contract.
• Identify members across multiple populations and systems.
• Monitor, track, and resolve any discrepancies between the enrollment files and the Bidder's system (e.g., duplication of records and information mismatches).
Page Limit: 2

Experienced Partner

Nebraska Total Care has been a proud partner of Nebraska MLTC (MLTC) since the launch of Heritage Health in 2017. We view enrollment and eligibility processing as the first critical step to ensuring that members receive timely access to healthcare services and currently process over 1.4 million inbound member enrollment records per year for Heritage Health. Additionally, we support our HIDE SNP eligibility and enrollment in collaboration with MLTC, as demonstrated through our implementation of Change Health care's data feed that is used to support our ability to check eligibility and process potential HIDE SNP members in the near real-time.

Completing Updates within Specified Timeframes

Our MIS supports automated file exchanges with MLTC, and we currently meet 100% of eligibility enrollment updates within the specified timeframe. We receive, process, and update the enrollment file in a variety of frequencies (daily, hourly, or real-time). In alignment with Section V.R of the Scope of Work, we will update our eligibility and enrollment databases for all enrolled services within four hours for most recipients and in no case later than 24 hours of receipt of these files.

Daily File Processing. Upon receipt of an eligibility/enrollment file, our job scheduling software manages membership data load processes. Inbound files are automatically processed through our EDIFECS system for HIPAA 5010 compliance validation. EDIFECS, in conjunction with our middleware, edits for duplicate member records, date criteria validity, field data integrity, and valid date spans. Any membership records that trigger edits default into an Exception Report, where they are systematically corrected using data correction routines before subsequent processing. Membership update records not on the Exception Report are then loaded into our Unified Member View (UMV) eligibility and enrollment system through "Add, Delete, and Modify transactions" with accurate begin/end dates. Once member data records populate in UMV, they are systematically promulgated to our other systems. Our integrated Management Information System (MIS), for example, UMV, claims are updated within 24 hours of receiving eligibility and enrollment files. Additionally, we send daily member eligibility/enrollment updates to our subcontractors, including our Pharmacy Benefits Manager, NEMT, and vision Subcontractor. In support of the new contract, we will include our dental Subcontractor in daily member eligibility/enrollment as well.

Identifying Members across Populations and Systems

Eligibility and Enrollment Database. Our MIS employs a Master Data Management and Service-Oriented Architecture (SOA) design, in which each software component (eligibility/enrollment, claims to process, etc.) serves as the system of record for its data subject area and all core systems exchange transactional data via a middleware-enabled SOA data bus. Similar in design to a Master Patient Index application, UMV uses a CMS Medicaid Information Technology Architecture (MITA) informed design for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing the member data we receive from MLTC throughout our organization to ensure consistency and control in the maintenance of member data. UMV serves as the system of record in our MIS for eligibility and enrollment data, ensuring member data integrity across our integrated MIS system components requiring that information, for example, our TruCare Cloud Care and Utilization Management system, Claims System, our Customer Relationship Management platform, etc. to support member engagement, clinical applications, claims, portals, and reporting applications.

Eligibility and Enrollment Across Populations. UMV supports all informational aspects of our member's relationship with Nebraska Total Care across a member's continuum of care for our Nebraska programs. This includes Medicaid, CHIP, and Medicare through denotations such as member identifiers, contact information, special needs, and member preferences, along with a history of any change to each attribute.

Detecting and Managing Duplicate Records. As 834 and supplemental files received from MLTC are loaded, UMV edits for duplicate member records, date criteria validity, field data integrity, and valid date spans. UMV then loads the validated enrollment roster data into member files while discarding inaccurate information. UMV includes matching logic and gives us the automated ability to link an inbound member record with historic eligibility spans we may have on that member. Connected to UMV, our Customer Relationship Management (CRM) is equipped to store multiple-member identifiers that can be used to identify each member across all systems, including the member's Medicaid ID number and our master person identifier (MPI) number. The ability to house and integrate multiple identifiers enhances our ability to maintain

historic member data that results in a unified view of a member's enrollment history. Additionally, we can systematically identify duplicate records for a single member and subsequently resolve any duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged.

Monitoring, Tracking, and Resolving Discrepancies

Nebraska Total Care's Enrollment and Data Analytics Teams monitor enrollment and disenrollment trends through our Daily Oversight Dashboard. The Daily Oversight Dashboard tracks member processing in terms of adds, reinstates, changes, terminations, voids, continues, and errors. We also use an Eligibility Processing Dashboard, which integrates with all system components that require eligibility data. The Eligibility Processing Dashboard electronically receives detailed information on each eligibility record from receipt through each downstream interface. We can track the status of eligibility updates via drill-down capabilities allowing us to identify potential issues immediately. The Eligibility Processing Dashboard has full reporting capabilities to trend eligibility updates and reconciliation operations, spot trends, and inform continuous quality improvements. Our comprehensive monitoring ensures we process all files in the State's designated timeframe.

If our Eligibility Specialist cannot resolve any identified errors, we notify MLTC of the errors that would prevent Nebraska Total Care from proceeding to the next step, for example, final load to production UMV. The Eligibility Specialist then initiates the production load and reviews a load report to ensure that all members were successfully loaded into UMV. The Eligibility Specialist is responsible for resolving any errors or warnings (for example, potential duplicates) until there are no load errors or warnings and contacts MLTC if there are unresolvable issues. We also track load errors over time to spot any errors and use this information to identify potential issues and (if needed) work with MLTC to resolve the issue.

Resolving Discrepancies Between Eligibility Files and Internal Membership Records. Our MIS is specifically configured for reconciliation of eligibility/enrollment data from MLTC, including non-834 data from the Supplemental Enrollment File as compared to our membership records. We conduct reconciliations of the daily enrollment and monthly disenrollment activity against our records through a variety of reports. See **Table 101** below.

Responsive Partner

On the occasion we receive an ad hoc notice by MLTC of member updates, we consistently update our records and respond within 24 hours demonstrating our efficiency and commitment to resolving discrepancies.

Table 101. Enrollment Reports

Report	Description
2400 Error Report	The 2400 Error Report identifies when the member's assigned PCP either does not qualify or is not accepting new members. For these errors, Enrollment Processors review and update the PCP error in our Claims Processing System.
Dual Members Report	The Dual Members Report identifies members with retroactively assigned Medicare coverage.
Recouped Members Report	The Recouped Members Report identifies members voided by the State's fiscal agent.

We also use MLTC's 820 files each month to reconcile the member level information in the 820 detail premium remittance data with our membership records in UMV, and we then address any discrepancies, including duplication, via an Exception Report with MLTC (or as otherwise directed by MLTC). If a duplicate record is confirmed by MLTC, our MIS can ensure member interactions and histories of the duplicate records are linked and merged.

102. Provide a description of the Bidder's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities.
Page Limit: 3

V.R Systems and Technical Requirements

Comprehensive Security Management Functions

Leading Innovation and Best Practices

Nebraska Total Care administers Heritage Health on a Management Information System (MIS) operated by our parent company, Centene. Through our ISO 27001 Certified Security Program, we employ recognized standards governing the security of State and Federal data processing systems. We provide MLTC access to our data processing facilities upon request and make information available to MLTC, State, or Federal representatives to evaluate the services we perform.

Security Certification

Our Security Program is International Standards Organization (ISO 27001) certified; a standard recognized worldwide.

Security Program Governance. Our Security Steering Committee oversees our Security Program Functions and includes the Centene Chief Security Risk Officer, Chief Information Security Officer, the Chief Information Officer, the Compliance Officer, and General Counsel. Our IT Security Department employs security controls and safeguards to assure data protection through our Security Project Management Office, under the guidance of the Security Steering Committee. Nebraska Total Care's Information Management and Systems Director and Contract Compliance Officer are responsible for assuring that all State security requirements are communicated and addressed by the Security Steering Committee. We employ policies, controls, and monitoring tools for compliance to security standards for information exchange, access restrictions, and data integrity, including all requirements in RFP Section IV.R.9. In conjunction with Centene, we perform annual security risk assessments and penetration tests, and we will communicate the results of all assessments to MLTC before the operational start date and every year thereafter. In addition, we retain a nationally recognized HIPAA security audit firm to perform an independent Security Risk Analysis biannually that adheres to the NIST 800-30 framework. We also perform a self-assessment in conjunction with Centene Internal Audit and Privacy Offices annually. We will make summary results of both self-assessments and third-party risk analyses available to MLTC upon request. These reviews have had no material findings nor resulted in significant required corrective actions.

Security During Organizational Transitions. We comply with all Data Protection Requirements in Section V.R.m. Outside of our authorized staff, only our HIPAA Business Associates have access to Medicaid data, limited to their subcontracted responsibilities. In addition, in the event of any transition, as described in Section V.R.m.ii, our security controls and practices allow us to eliminate access to Medicaid data shifting to another organization after a transition period, while still allowing us to retain historical data as required by law. Our Nebraska Access Control Standards, Policies, and Procedures specifically address the required separation of duties for any potential organizational transitions.

Securing Information. All data at rest and in motion is encrypted by our HIPAA-compliant technologies, including AES-256 encryption, SFTP, Secure Sockets Layer (SSL), Transport Layer Security (TLS), and Virtual Private Networks (VPN). Our data loss prevention technology (DLP) controls Protected Health Information (PHI) data usage through automated content analysis for identifying PHI in e-mails, files, and documents and monitors data in motion as well as at rest. If DLP detects confidential information (including PHI) contained in transmission to an unidentified/unapproved destination, DLP quarantines the transmission and e-mails the sender with instructions to contact our Compliance Department and supply the reasons for the attempted transmission. Our compliance staff then reviews the DLP event and takes appropriate action, which can include approval of the transmission, incorporation of the destination to our whitelisted list of destinations for future transmissions, or (if the transmission was inappropriate) blocking of the transmission and potentially recommending disciplinary action. We also enforce two-factor authentication and the use of VPN for remote user access to our MIS. Through our use of Access Control Lists (ACL), Web Proxies, Demilitarized Zones (DMZ), firewall rules, and a security domain enclave approach to sub-networks, we prohibit access to our internal MIS applications from the Internet.

Best in Class Controls

As a State and Federal contractor, all our security controls are certified as compliant with ISO, FedRAMP, and other recognized standards.

Scanning Software. Our IT Security Team scans any software update before release into our production systems. If a

vulnerability is found after release, our Threat and Vulnerability Management Team (TVM) coordinates with our Patch Management Team for the application of patches and re-scanning until the software meets our security standards. We configure all end-user devices so that users cannot install application software (nor use removable media on their device) without the approval and support of the IT Security Team. Our Nebraska Total Care Compliance Team(s) validates the security configurations of company-issued laptops by performing an annual random sample audit that checks for appropriate software installation and ensures that no unauthorized software can be installed and that USB devices are unusable.

Access Restrictions for Hierarchical Functions

Through our identity management and access control system, we implement Role-Based Access Controls (RBAC) for all applications that process PHI. Our RBAC system defines user access rights based on the user's job responsibilities, including whether the user has access rights to update information or view only. We use our RBAC controls to also enforce hierarchical responsibilities that reflect our organization. For example, a Care Management Supervisor may see information related to his subordinates, but those subordinates may not see all the information accessible by the Supervisor. In addition, individuals responsible for granting access do not themselves have the rights to perform transactions within those applications; for example, the administrator who manages login profiles to our claims system cannot herself process claims. Individual security change requests are recorded through our documented security authorization process. Our access policies and controls are based on HIPAA Minimum Necessary rules and a least privilege approach needed for staff to do their jobs. We do not grant any staff global access to MIS functions and our access management controls automatically lock out users attempting to access PHI-bearing applications after three unsuccessful attempts. These attempts are recorded in our system logs and are available to our IT administrators to investigate if needed, for example, if there is an increased number of lockouts. We use reports from our RBAC system to support the regular, documented attestation by our managers of appropriate subordinate access to systems.

Audit Trails: Auditing Systems Access and Usage

Our system owners regularly review access to critical applications, databases, and operating systems to ensure that employees have HIPAA Minimum Necessary access needed for their jobs. We use our Security Information Event Manager security system (SIEM) to maintain audit logs and transaction reports on user login activity and records viewed/edited. Our SIEM allows us to track user access by log-on ID (or system job) along with the date/time of any create/modify/delete activity. Our SIEM also allows us to audit individual log records as well as trace data from a final place of recording to the source data file and comply with all functions in Section IV.R.9.d. We maintain our audit logs online for two years, and (if not online) logs can be retrieved within 48 hours.

Annual Penetration Testing

We engage multiple cyber security firms annually to simulate threats. This includes external network perimeter testing, social engineering, vishing (phone fraud), phishing, internal network, and web application penetration testing. We use the results of penetration testing to identify and address any identified vulnerabilities.

Information Integrity

We use four sets of controls for information integrity: access controls to ensure that only authorized users are entering data appropriate to their role (as discussed above), edits for online entry and update of information, file exchange protocols with assured delivery controls, and a Master Data Management / Service Oriented Architecture (MDM/SOA) design for the control of the application to application data exchange within our MIS. We will jointly develop with MLTC a process and methodology for periodic spot audits of our data integrity controls.

Data Entry Field Level Edits. All our applications, including those on the web, enforce an appropriate degree of field-level edits, ranging from alphanumeric formats, for example, HIPAA standard lengths for name fields to more sophisticated edits (NPI check digit validation), to the use of drop-down lists to prompt data choices, to field logical checks, for example, if the user enters a value in one field, this drives the mandatory entry of data in another field.

Data and File Communication Controls. Our data communications controls allow us to send and receive formatted data (including HIPAA and HL7 transactions, and state proprietary formats) using audit controls at the file and data level. At the file level, we use automated scheduling software to monitor if inbound and outbound files are being received and transmitted and to alert us if files are not being exchanged per schedule. At the data level, we use EDI TA1 Interchange and 999 Functional Acknowledgements, as well as balance reports and state proprietary formatted reports to assure that we systematically account for records sent and received.

Service-Oriented Architecture (SOA). Our MIS design is informed by Medicaid Information Technology Architecture (MITA) principles, where each core system (enrollment, provider data, claims, etc.) is integrated using standard SOA middleware.

Each system is also the master of specifically designated data using MDM controls. For example, our Unified Member View (UMV) system is the master (system of record) for member demographic information, our Provider Lifecycle Management System is the master of provider identifiers/demographic/affiliation information, and our Claims Processing system is the master of claims information, etc. The combination of SOA and MDM principles allows us to enforce specific data integrity controls within the appropriate system of record while allowing each application to interface with each other via our message-oriented middleware architecture supporting microservice calls, automated Extract / Load / Transport (ETL) processes, database interfaces such as Open Database Connect (ODBC) and Change Data Capture (CDC) processes. Once data is received into our MIS, it is not logically duplicated, and only the system of record can alter that data - an approach that assures the highest possible level of integrity for downstream reporting and information support. In addition, inherent in our MDM design, no finalized records can be altered, and we maintain change history on records for a variety of uses, for example, research on claims, audits, and historical analyses.

Physical Safeguards

Nebraska Total Care's MIS is housed in three enterprise data center facilities, all wholly owned by Centene, which house Nebraska Total Care's data and voice communications systems and are securely connected to Nebraska Total Care via our internal Wide Area Network (WAN). All data centers feature environmental controls, including automated fire detection, alert, and retardant systems. Each data center is secured via proximity card access on all external doors, elevators, and the internal entry doors on each floor. Security guards at our datacenters require that all visitors sign in and out at the front desk, utilize a temporary badge, and are accompanied by an employee when visiting. We also use digital security cameras, multiple security guards who are always on duty, and panic switches installed at each reception desk. Our card key system records all access attempts/card swipes, whether successful or not. When requested, we will provide access to our data center for authorized MLTC staff.

Additional Safeguards Ensure Secured Systems Access

Policies and Procedures. We annually refresh standards, policies, and procedures to ensure all our employees and subcontractors comply with Nebraska and Federal security requirements. We review and update these documents via our Compliance Management System which provides workflow-enabled policy and procedure formulation with auditable history. All policies and procedures are available to our employees and authorized subcontractors, online, via our intranet, and are searchable via categories and search words.

Information Security Training. Our online training courses are required upon hire of all system users, and annually thereafter. Our training includes information security essentials, insider threats, Internet phishers, and more. We track the completion of courses and send reminders when annual course completions are due. Our IT Security Department maintains our online Centene SECURE training center. SECURE includes security reminders, bulletins, and more. We also launch regular simulated phishing campaigns where users receive test emails and receive an instant notification if they successfully report the simulated attack, or a warning if they attempted to open the test e-mail. SECURE also promotes recognition of employees who have demonstrated excellent security diligence (such as reporting suspicious e-mails to our Report2Cyber security center for follow-up), as well as access to online training. Nebraska Total Care also conducts local training throughout the year as well as monthly Employee Newsletters, email communications, lunch and learns, and interactive challenges including security quizzes to test employee knowledge of Nebraska Total Care security practices.

Additional Security Function Examples. Our security program includes a comprehensive set of safeguards. We cite only a few examples in Table Q102, to offer additional perspective on the scope of our controls:

- We have **anti-virus software** and host-based **intrusion software** on both PCs and servers for malware protection.
- Desktop **PCs** are **diskless**; **Laptop** hard drives are **encrypted**. **Mobile** devices are systematically **tracked/monitored.**
- **Desktop** machines are **physically locked**. Users **attach laptops** to desks with **cable locks** or **locked**-in **filing cabinets.**
- Movement and disposal of **all PCs** and **mobile devices** are **tracked** through our **Asset Management System.**
- **Intrusion Prevention Systems (IPS)** for advanced **network monitoring** and **defense**. IT Security staff are automatically alerted to IPS events and follow industry best practice incident response procedures.
- **The Vulnerability Management System continuously assesses** our **MIS** against a library of existing and new exploits. Risks are addressed using approaches such as firewall rules, administrative controls, and other safeguards.

103. Describe the Bidder's business continuity, contingency, and recovery planning. Attach a copy of the Bidder's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery:
• Operational and system redundancy in place to reduce the risk of down-time.
• System and operational back-up sites.
• Contingency and recovery planning including resumption of operations.
• Prioritized business functions for resumption of operations and responsible key personnel.
• Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable.
• Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith.
• Testing approach and regular schedule to improve and update the plan over time.
Page Limit: 3 Excluding sample plan

Business Continuity, Contingency, and Recovery Planning

Our Contingency Plan employs Business Continuity (BC) and Disaster Recovery (DR) best practices to anticipate and respond to emergencies and disasters on time. We engineer the hardware, software, and processes in our Management Information System (MIS) to ensure high availability of applications, appropriate partitioning, systems monitoring, and prioritization to ensure IT systems and data are available to members, providers, and Nebraska Total Care staff after disaster identification. Centralized services in our enterprise-wide data centers provide resiliency and redundancy in the event of an emergency or disaster. DR planning. We view BC and DR planning as a high priority to ensure service excellence. Our continuity and recovery solutions allow for a variety of response options depending on the type and severity of the event.

Business Continuity in Action

Due to our robust BC and DR Plans, Nebraska Total Care met annual Member Service operating levels before and during COVID-19. All information systems remained online and available, including core systems, websites and secure portals, and data exchange subsystems. Additionally, at the beginning of the Public Health Emergency (PHE), our Care Management staff outreached to members to ensure they had a management plan and proper supports in place. We maintained the ability to receive eligibility data and saw no reduction in our ability to process claims and authorizations within required turnaround times. We lost no data during the PHE and our full-mesh, multi-vendor Wide Area Network allowed all staff to transition to a remote work environment quickly and seamlessly.

Operational and System Redundancy

To mitigate disruption of service and avoid loss of data, we own and operate three geographically separated enterprise data centers, connected by a fully redundant wide area network (WAN), where all our core application data is housed. These facilities employ redundant environmental, power, and networking systems, and backup capability, and are hardened to withstand natural disasters. For example, our data centers have a seismic importance factor of 1.5 and can withstand winds up to 165 miles per hour. As data is received or created in our production environments, it is immediately replicated in the associated recovery data center. In an event requiring a failover from the primary to the alternate site, we would leverage this backup replicated data and infrastructure located at the alternate site to continue essential business functions. This architecture provides our critical applications and infrastructure the necessary redundancy, resilience, and service stability to quickly resume essential business functions, for example, eligibility/enrollment, claims to process within 72 hours of the failure or disaster, and all remaining operations timely following a disruption.

System and Operational Backup Sites

System Back-up Sites. As noted above, data created in production environments is immediately replicated in the associated recovery data center for high-speed DR services. We perform complete system backups nightly on all servers utilizing enterprise-class backup software and online tape backup technology with off-site replication to our designated recovery data center, ensuring effective recovery and resiliency capabilities. Our DR processes leverage leading technologies and off-site storage to fully recover data and systems from the effects of a disaster and minimize the recovery period. In the case of an outage, the designated recovery data center will restore critical business services, including systems, databases, and applications. From there, all other systems and applications will be restored per MLTC priority to ensure MLTC satisfaction with our recovery capabilities and mutually agreed upon recovery time and point objectives (RTOs and RPOs).

Operational Backup Sites. We maintain policies and procedures to allow for remote work and remote access in compliance with HIPAA and the HITECH Act. All applications are run centrally from our data centers, and our standardized virtual desktops connect to centralized data via a redundant WAN. We review and update our procedures annually to align with industry best practices, risk assessments, and State and Federal mandates. Privileged remote access is provisioned only with

approval and role-based or business justification. We have consistently demonstrated our ability to maintain operations in a remote work environment and have adapted to changing operational priorities to best serve our members and providers.

Contingency and Recovery Planning

Through our parent company, Centene, we have access to enterprise-wide business continuity management (BCM) organization which provides support, coordination, oversight, BC plan development, and maintenance of our overall business resiliency. Nebraska Total Care staff, in partnership with this centralized organization, maintain and oversee our currently operational BC Plan, as well as supplemental continuity plans. Please see **Attachment B.103 Sample Contingency Plan** for a sample of our BC and DR plans (together comprising our Contingency Plan). We conduct regular updates of our BC plans by using scenario-based exercises. The frequency of the updates and exercises is determined by the plan's overall criticality. Our DR plan protects the availability, integrity, and security of data during unexpected failures or disasters, and addresses all scenarios in Section V.R.11.d. Updated at least annually, the plan includes comprehensive and clearly articulated data backup and emergency mode of operations policies and procedures and is compliant with HIPAA, 45 CFR 164.308, and relevant State and Federal regulations. We will submit a Contingency Plan to MLTC for review and approval no later than 45 calendar days before the Contract Start Date.

Supporting BC and DR Plans. We also maintain several supporting plans detailing emergency response, crisis and incident management, and Public Health Emergency (PHE) operations procedures. These supporting plans are based on protocols established by the World Health Organization (WHO) and the Centers for Disease Control (CDC) to respond to and recover from situations impacting our employees and business operations. Our PHE plan provides strategies to reduce PHE-related impacts on our staff and operations.

Prioritized Business Functions and Responsible Key Personnel

Prioritized business functions include member and provider call centers that rely on our telecommunications system, claims processing, eligibility and enrollment processing, member Care Management, provider enrollment, and data management, encounter data management, and data interfaces with the State. Responsible key personnel include our Chief Executive Officer (CEO), Chief Operating Officer (COO), Contract Compliance Officer, Member and Provider Services Managers, members of our Operations team, and our BC Planning and Emergency Coordinator who is responsible for ensuring the maintenance of our BC processes and procedures, including ensuring continuity of benefits and services for members during disasters and our emergency management plan. Our centralized BCM, DR teams, IT Site Reliability Engineers, and Incident Response Operations Center (IROC) also work collaboratively with our Nebraska Total Care staff to coordinate our response to any incident or disaster and restore services/application access or prevent an outage.

Employee and Supplier Training and Communication

Communication. We use our Emergency Notification System to ensure swift notification to impacted staff members in a crisis or emergency, no matter what happens to local or regional communications systems. The system sends voice, SMS text, and email messages to all available contacts in our human resources information system to provide critical information on delayed office openings, building power outages, hazardous weather, evacuations, and system unavailability. Not only do we have staff trained on this notification system locally, but should a disaster inhibit our ability to notify our staff locally, our trained affiliates across the country not impacted by a local disaster will operate the system on our behalf, ensuring 24/7 coverage and redundancy. Further, our Contingency Plan has structured communication processes used to contact suppliers and MLTC in the event of a disaster or emergency impacting system availability. Our Contract Compliance Officer is responsible for providing MLTC with a detailed explanation of the disaster and its impact on critical path processes, for example, enrollment management, encounter submission upon disaster, or disruption discovery. For extended disruptions, we will provide MLTC with a detailed plan to resume operations.

Training. We use several methods to train and educate employees on BC and DR topics. Training programs and presentations for crisis management, DR, emergency response, and BC are available through organizational and enterprise-wide channels. As more employees safely return to regular in-person engagement in our office spaces, we will periodically conduct emergency preparedness drills to review emergency actions, such as evacuation routes, weather policies and procedures, tornado shelters, and fire and earthquake procedures. In addition, BCM will partner with our local leadership response team to conduct tabletop continuity exercises based on plan priority, which serve the dual purpose of highlighting recent plan updates, as well as refresher training for our key employees. These exercises help ensure all key staff understands their roles and responsibilities during a disaster. Information about our plans is always also available to our leadership response team. We also review our BC plans to ensure we have contacts and protocols with key suppliers for coordination if our BC plan is invoked.

Ensuring Continuity of Care and Provider Payment

Communication with Providers and Members. As part of our overall preparedness for care continuity, we communicate to our Nebraska providers that we will suspend the need for prior authorization requests during an emergency that disrupts communication to prevent service interruption for Members. We can quickly update our website to notify providers of changes like this, as well as provide emergency-appropriate information for providers and members, including tips for preparation, where to access resources, alerts, updates, and service outage notifications. All data populating our secure Provider and Member Portals is housed in our data centers, ensuring member record accessibility for providers and members no matter where they are in the event of an emergency. Further, our Care Management staff conducts outreach to members as appropriate to review emergency plans and develop specific strategies to ensure they have access to necessary resources and continuity of care. For example, we have created member backup plans to ensure members on ventilators or tracheostomy tubes have power or a backup generator. We have even assisted in coordinating the relocation of members to safer locations near a hospital. We conduct regular claims and authorization data analyses to identify members most at-risk in an emergency to prioritize outreach whenever a disaster occurs.

Call Center Operations. In the event of a disaster, all business functions that rely on our telecommunications system will have top priority in maintaining continuity of care. Our Call Center is engineered with several levels of redundancy, allowing for immediate, automated rerouting of inbound calls to our out-of-state Regional Service Center or other affiliates. This ensures our members and providers do not experience a disruption in service or access to care. Our Call Center staff around the country have access to the Nebraska Medicaid knowledge base, including the MLTC-approved scripts, guaranteeing levels of service and consistently accurate information to members and providers.

Claims Operations. To ensure providers continue to be paid for the services during an emergency or disaster, our claims operations are supported by our claims processing centers located across the country. The centers are securely networked for voice and data connectivity with all data centers, as well as our offices. Our automated claims workflow system will instantly route our claims workload amongst any of the claim's centers, with staff at each trained center to handle our claims, ensuring provider payment is not interrupted.

Real-Time Emergency Monitoring. To supplement our emergency preparedness processes and expertise, we leverage customized solutions from a leading provider of emergency management and continuity services to track weather-related and other adverse events. Key personnel receive detailed, office-specific reports, dashboards, and email alerts coordinated with the National Weather Service or other governmental agencies, enabling us to proactively act on anticipated impacts. For example, we have access to an ***Interactive Common Operational Picture, which offers real-time visualization of all weather-related events likely to impact our offices***. The tool also predicts member impacts at the county level, so we can proactively outreach to those members to verify they have the supports they need and reinforce the continuity of care.

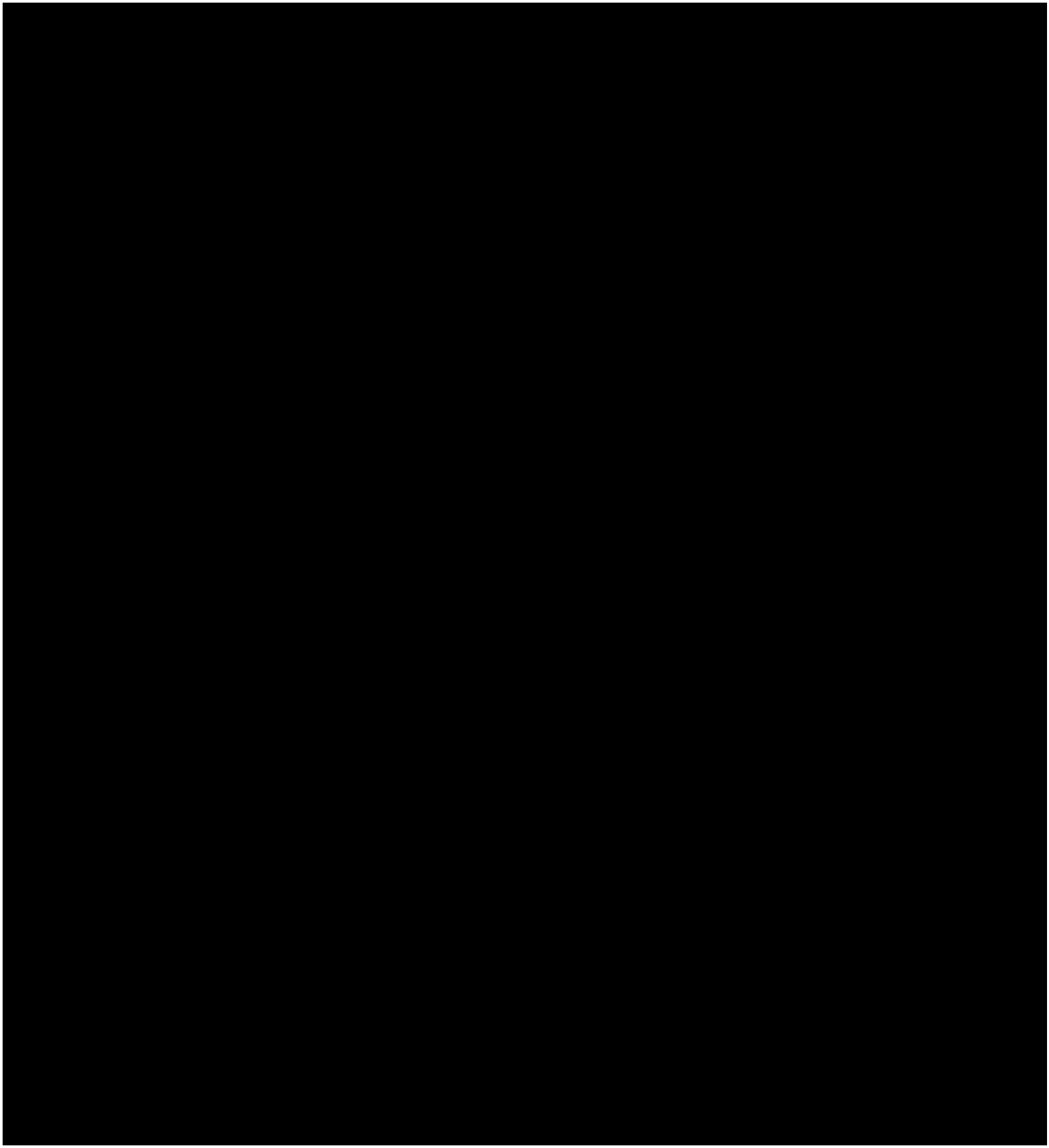
Testing

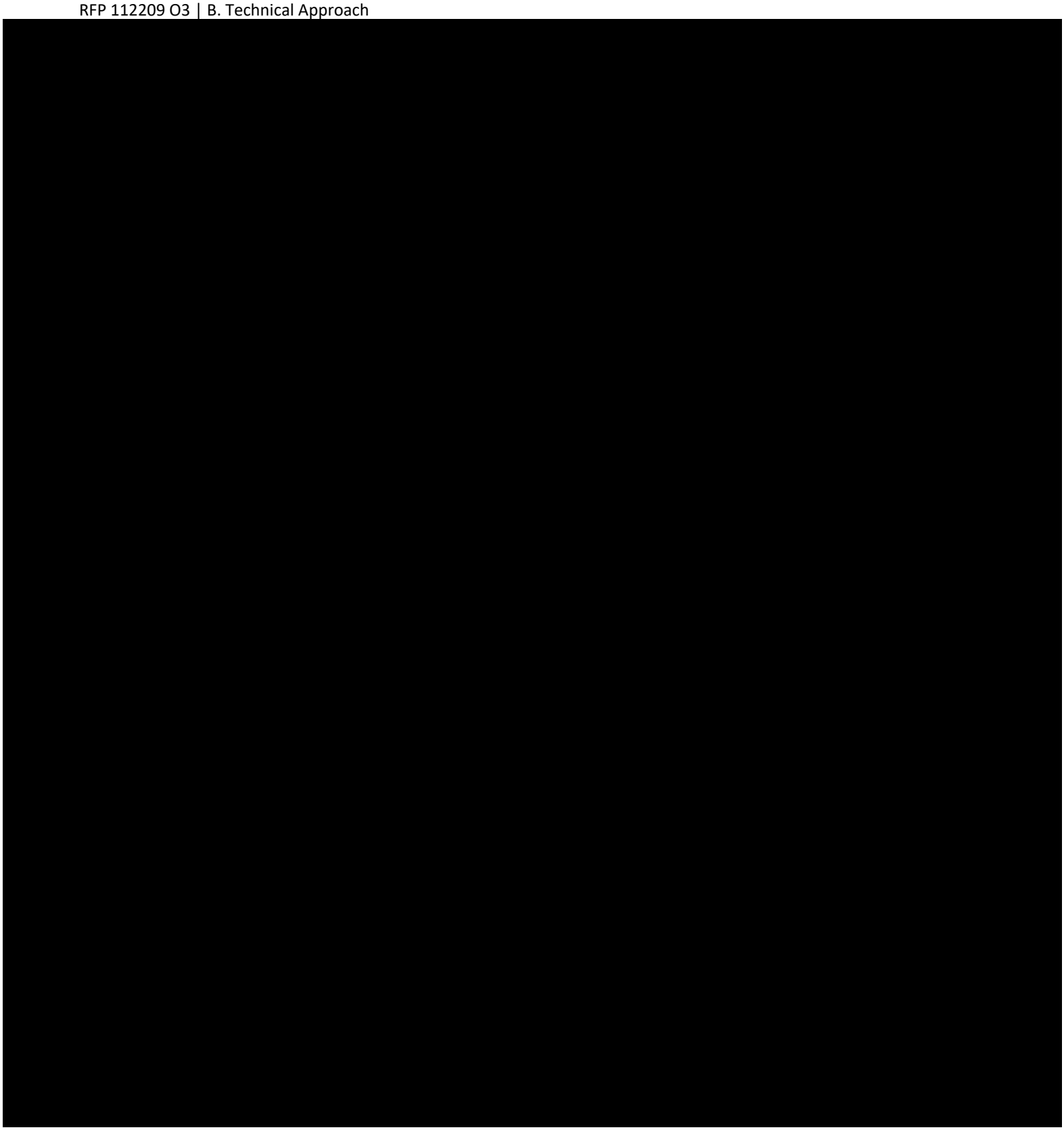
We partner with our centralized BCM and DR teams to maintain and test our BC, and DR plans annually as required by applicable State and Federal regulations. Such testing assures we meet RPOs and RTOs, and that our offices can continue to serve members, their families, and providers in the event a data center or system is unavailable. All our testing methods include structured documentation of lessons learned, which are then utilized to improve response times, address gaps, and improve and update the plan over time. Our BC and DR testing procedures include:

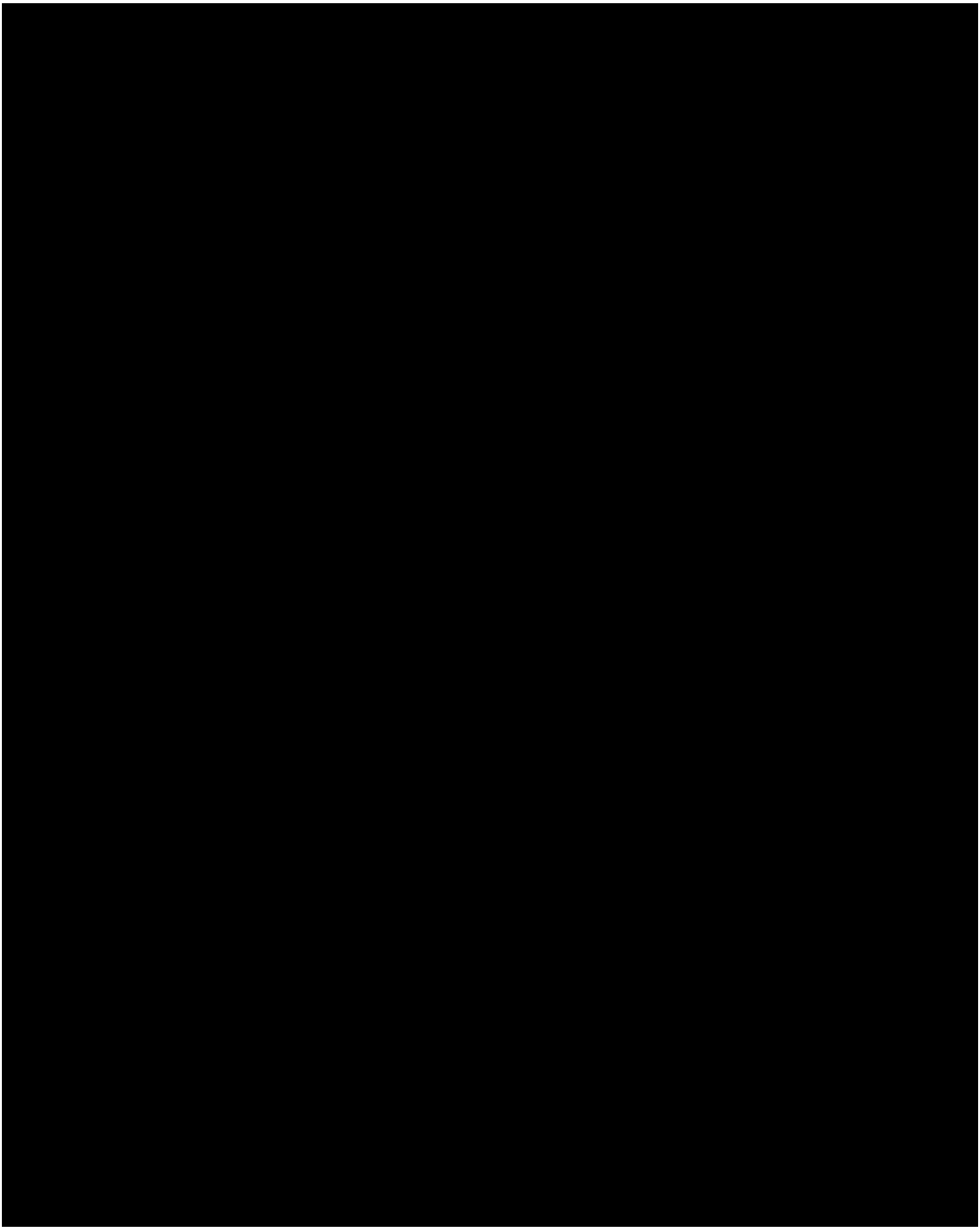
- **Annual DR Simulation Test.** We conduct full-scale, comprehensive testing of our MIS recovery capabilities by simulating a disaster to validate that we can deliver systems in an emergency. This simulation thoroughly tests all relevant hardware, software, personnel, communications, procedures, supplies and forms, documentation, transportation, utilities, and alternate site processing. We provide test results to MLTC annually. If we fail to demonstrate system function restoration, we will submit failure points or corrective action plans within 10 business days of the conclusion of the test. We approach interruption testing (actual activation of our DR strategy) with extreme caution and only conduct it as needed or required to avoid disruption of normal operations.
- **Walkthroughs.** We perform regular walkthroughs of the specific steps documented in our DR plans to confirm the effectiveness and identify potential gaps, bottlenecks, or other weaknesses. These walkthroughs reflect updated business objectives, allowing us to better respond to changing threats.
- **Parallel Testing.** We regularly conduct parallel testing by running reports on data in our primary and contingency data centers and comparing results to assess the effectiveness and accuracy of our backup and recovery processes. Output discrepancies would indicate needed process or technology changes.

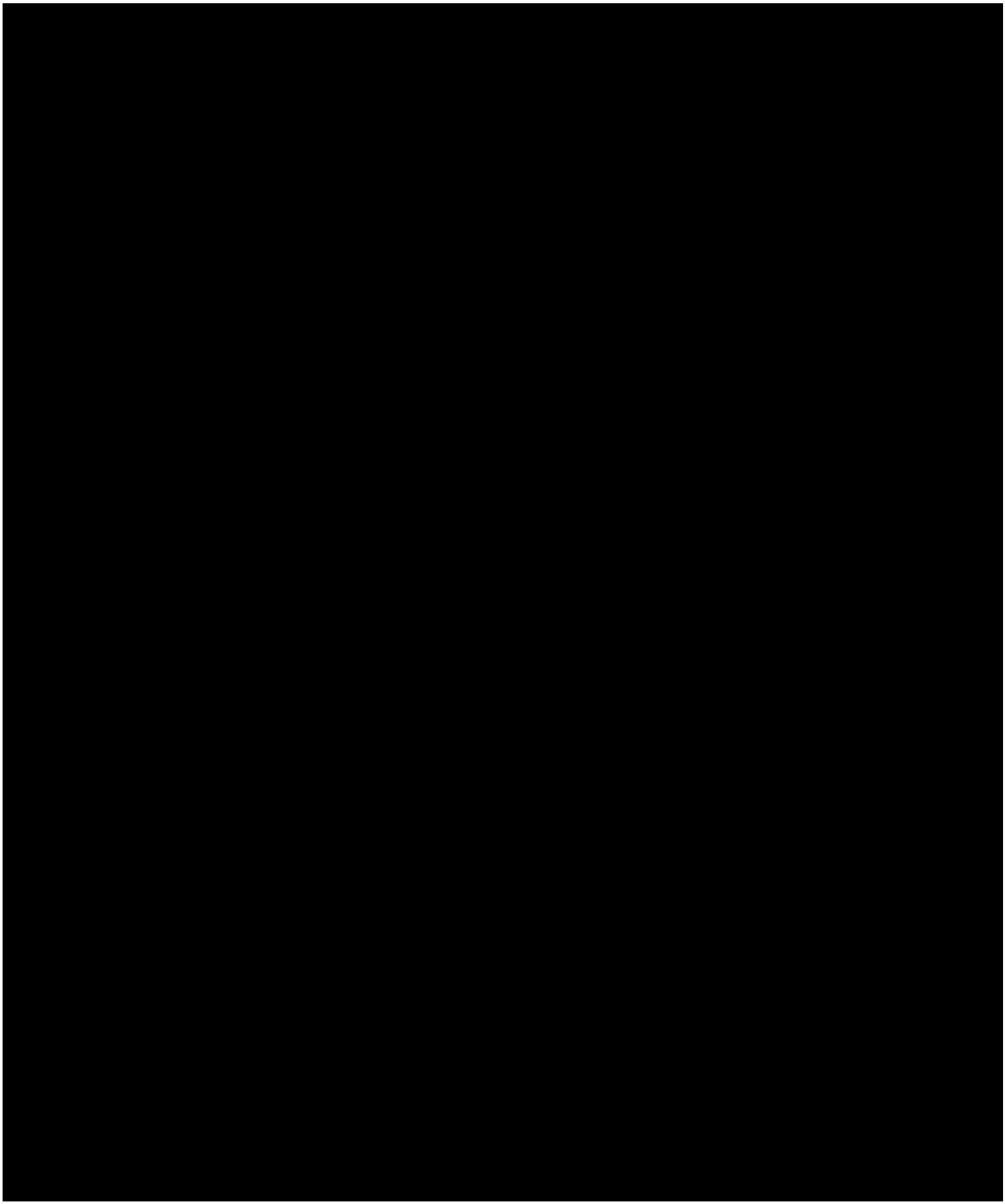
RFP 112209 O3

Attachment B.103
Sample Contingency Plan

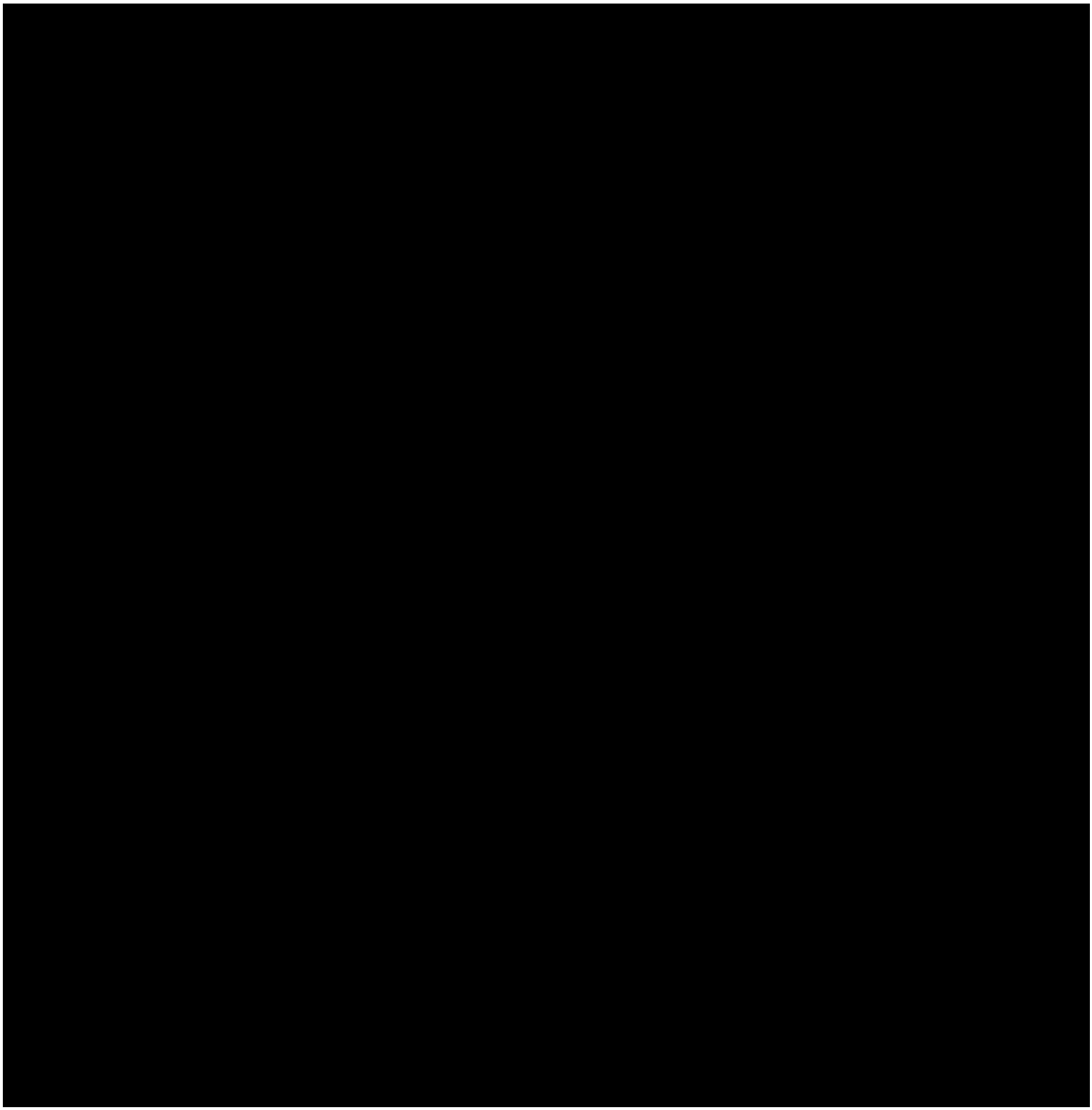


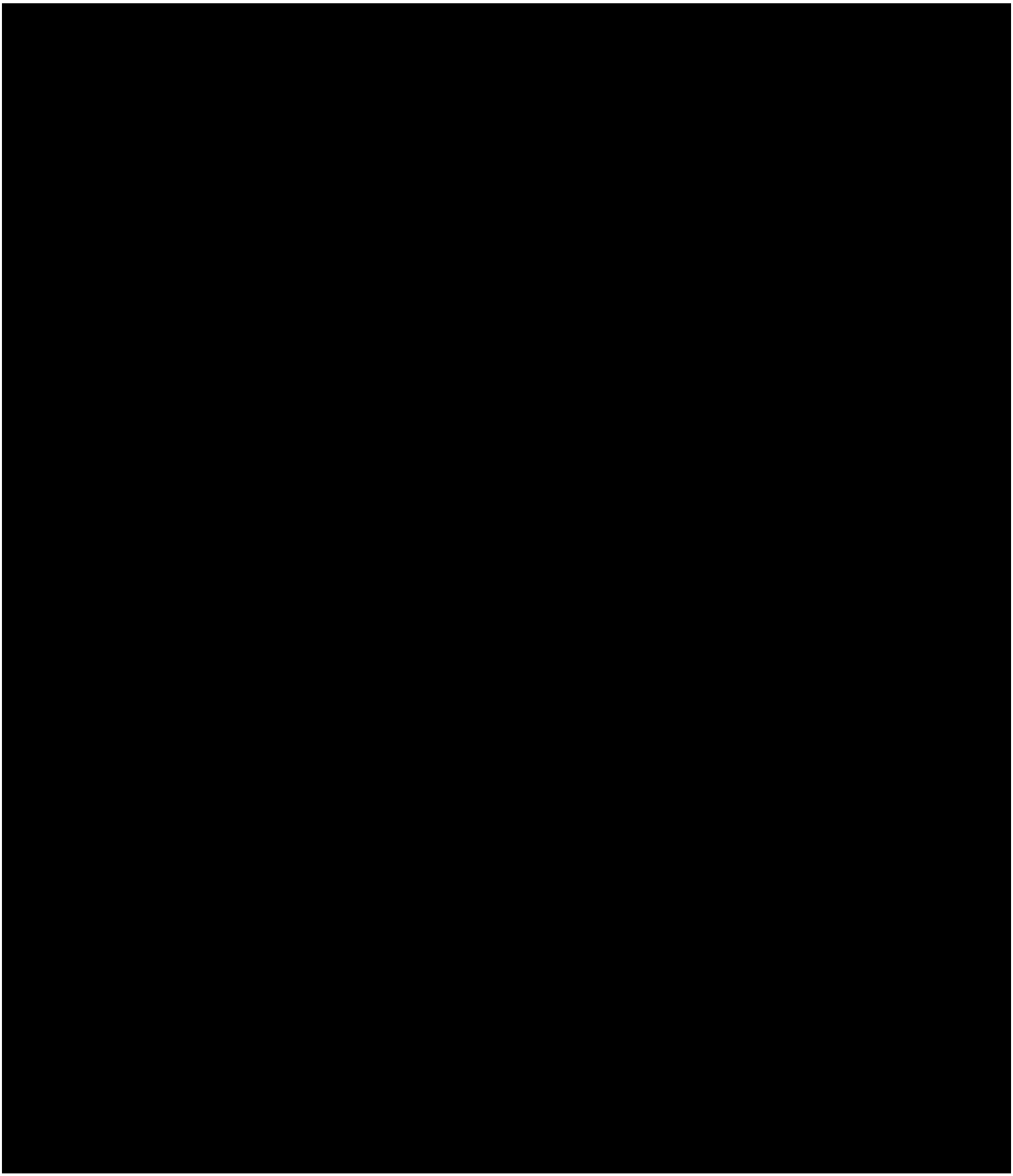


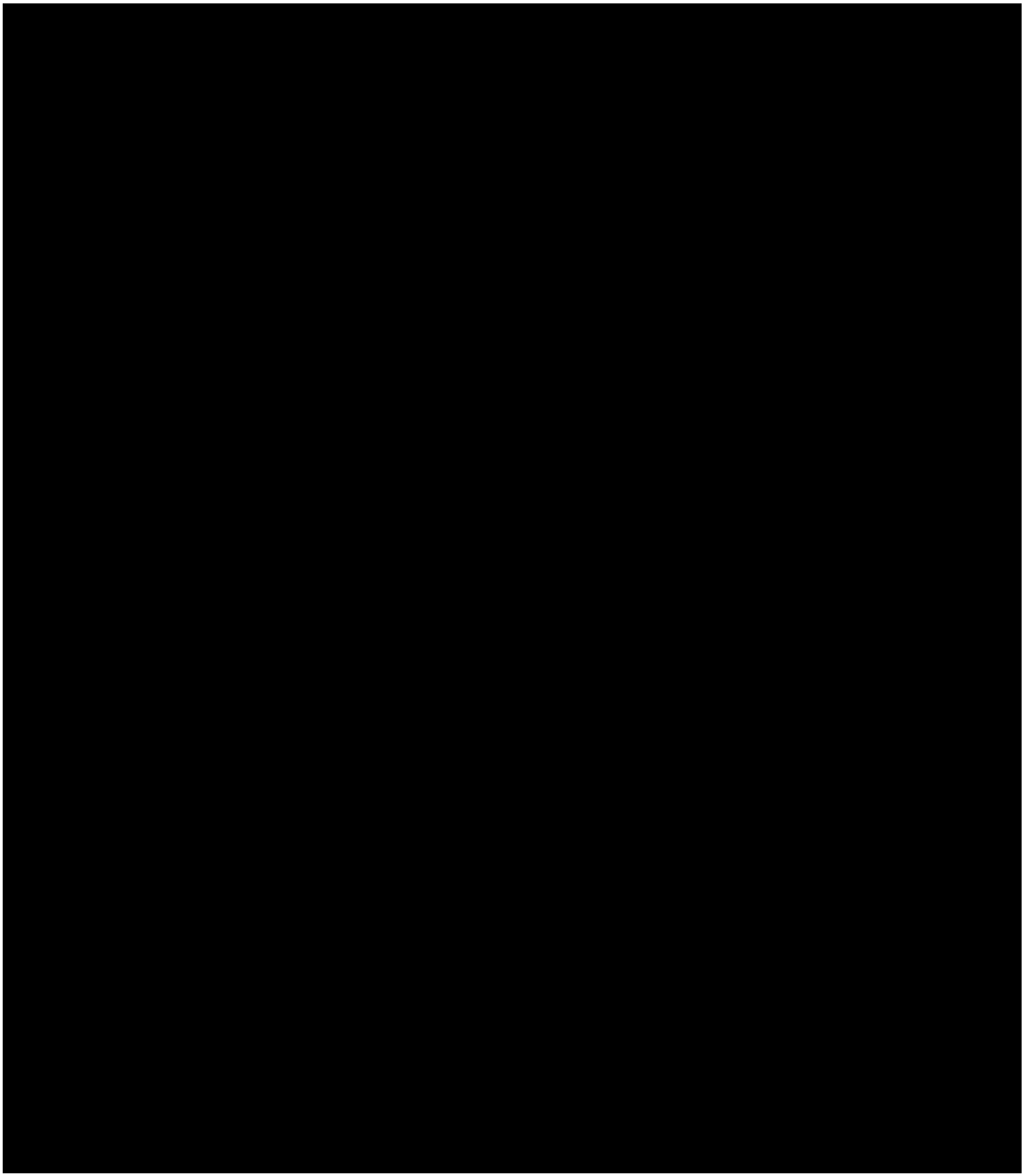


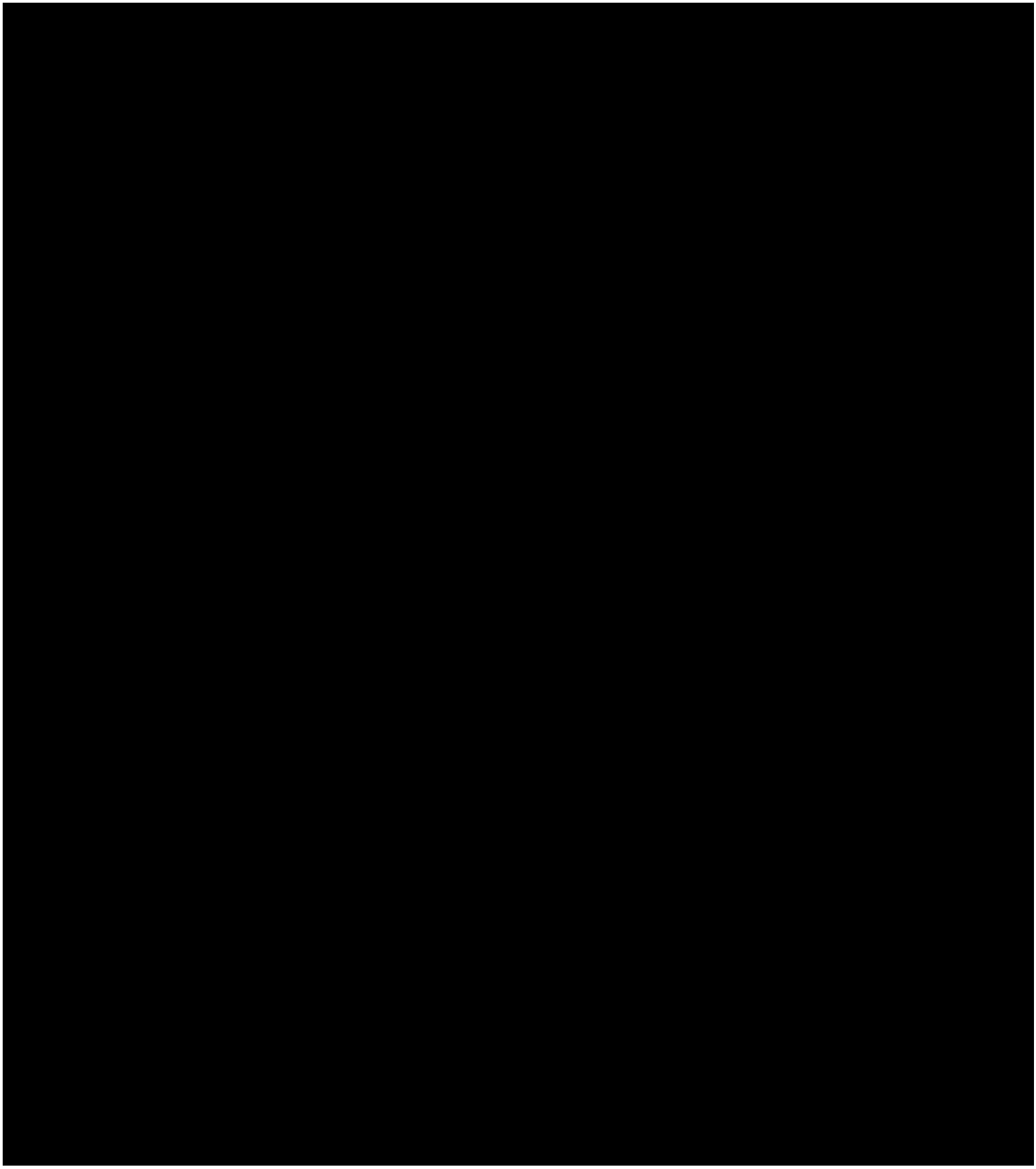


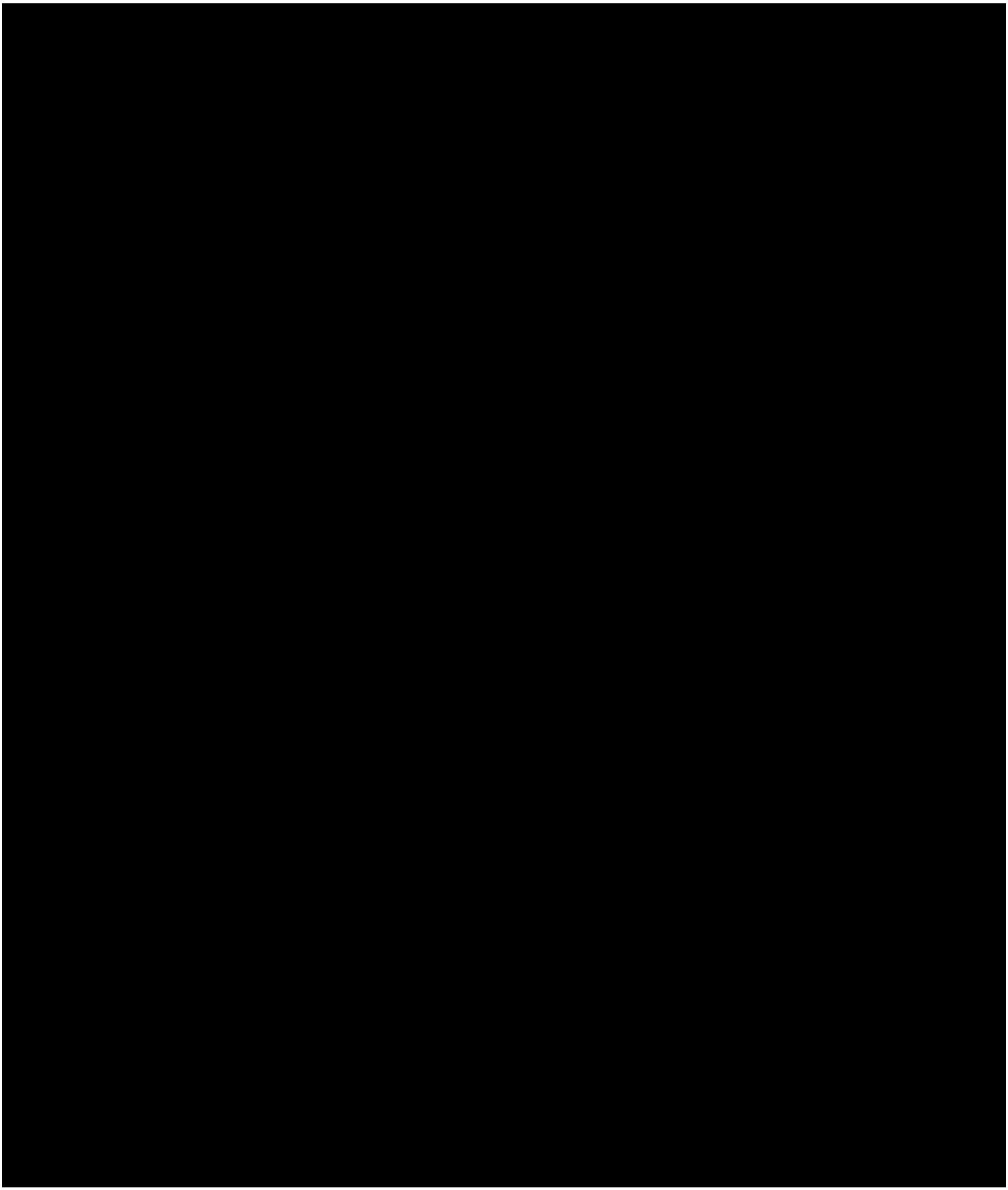
[redacted]

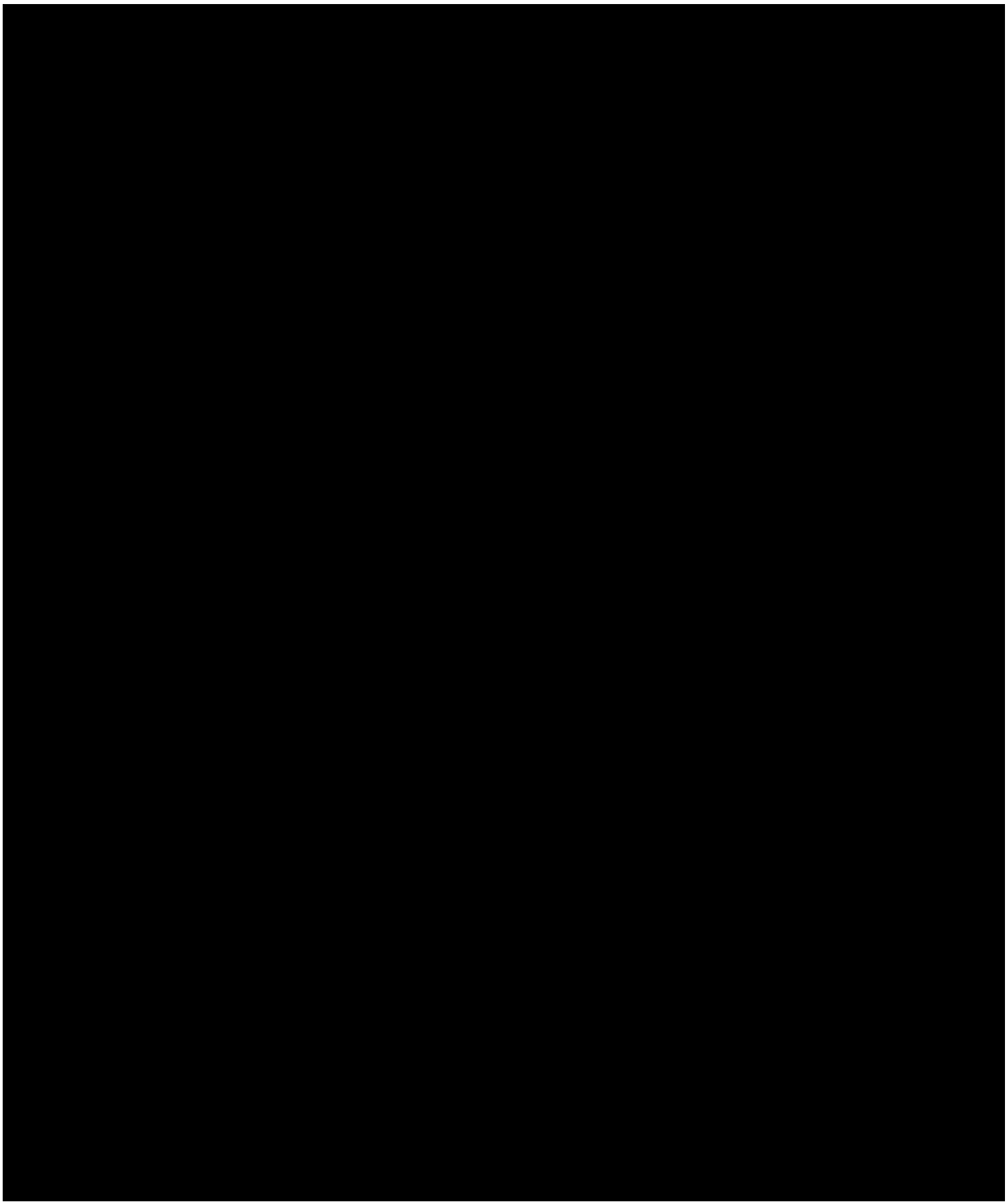


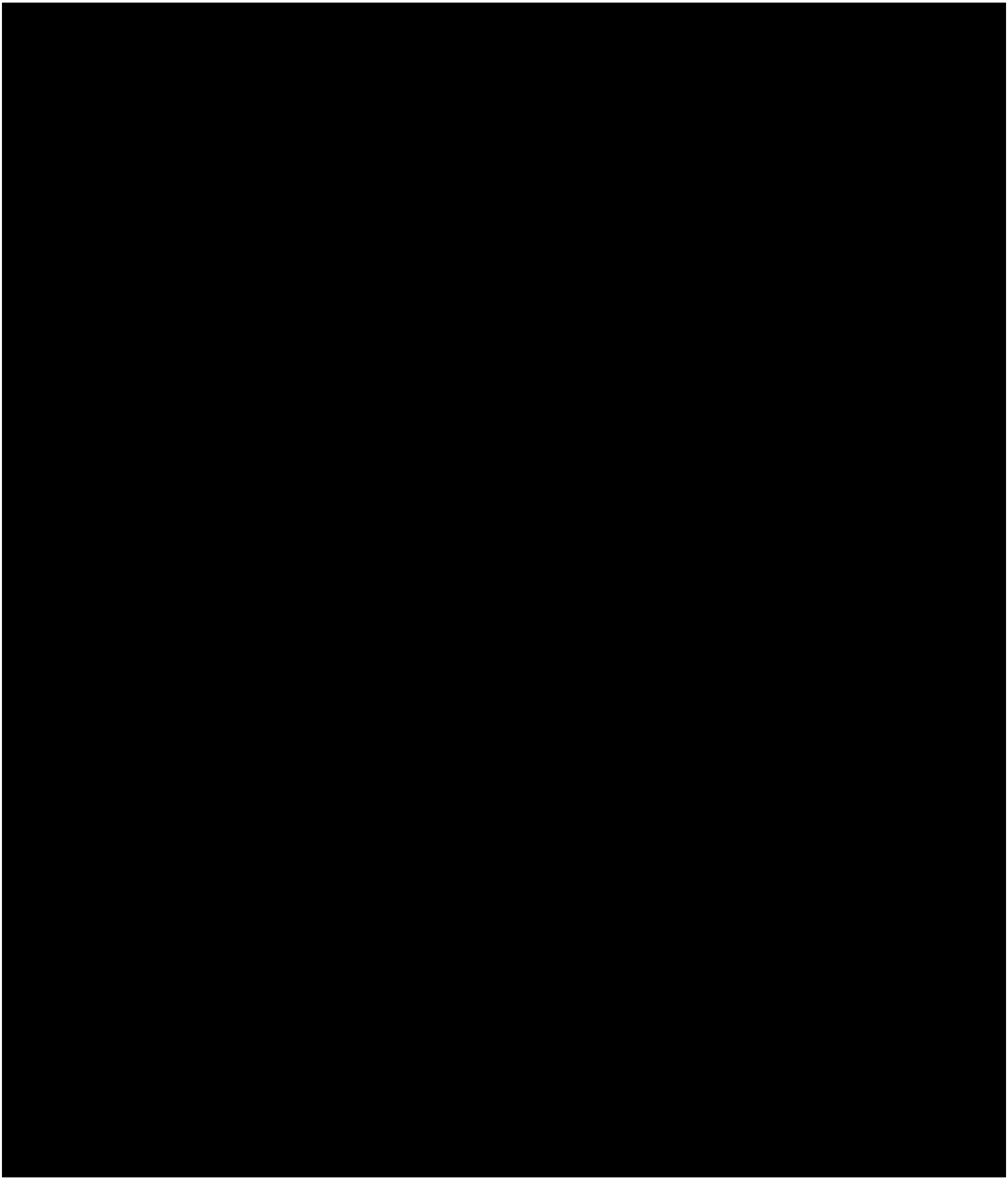


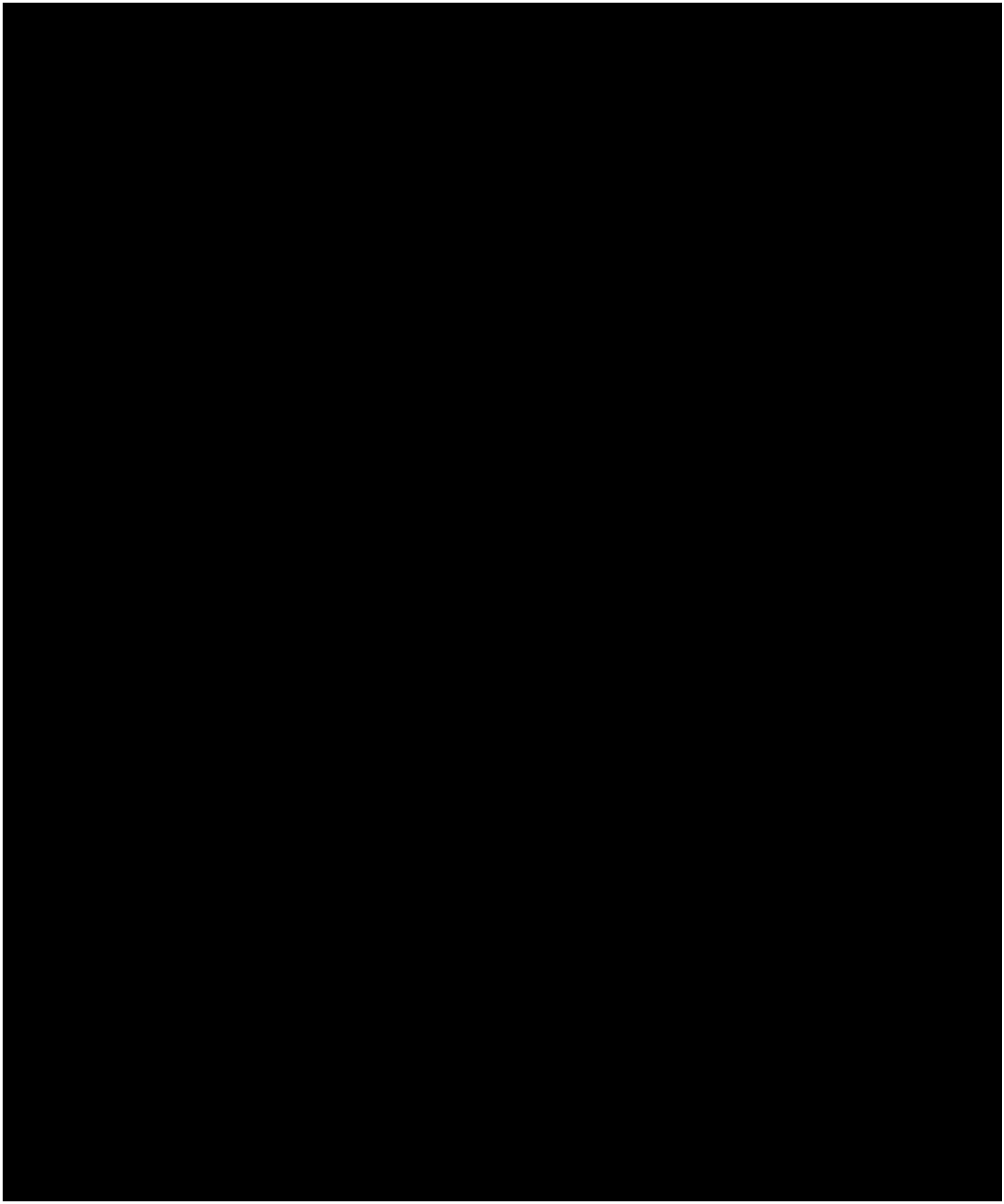


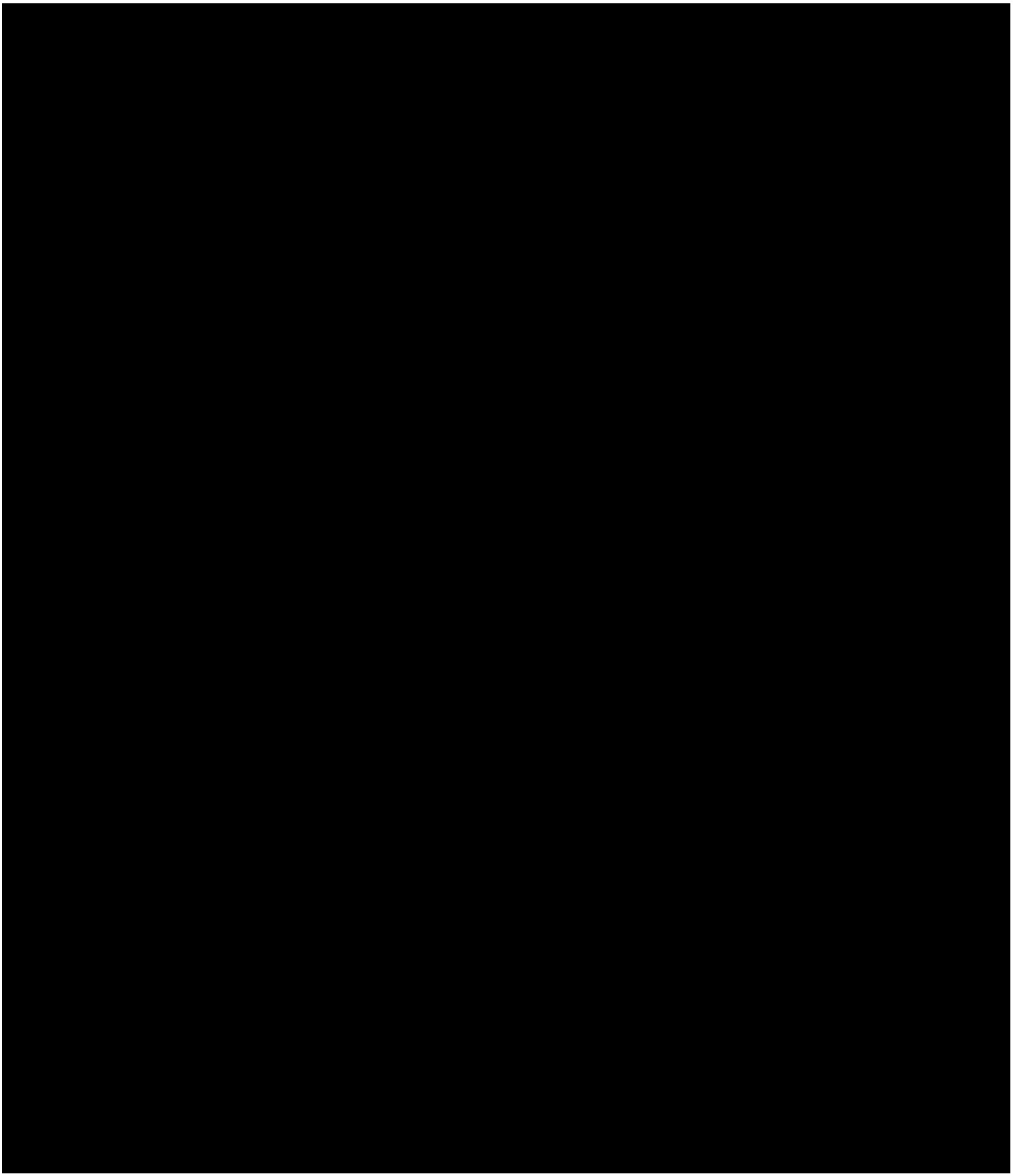


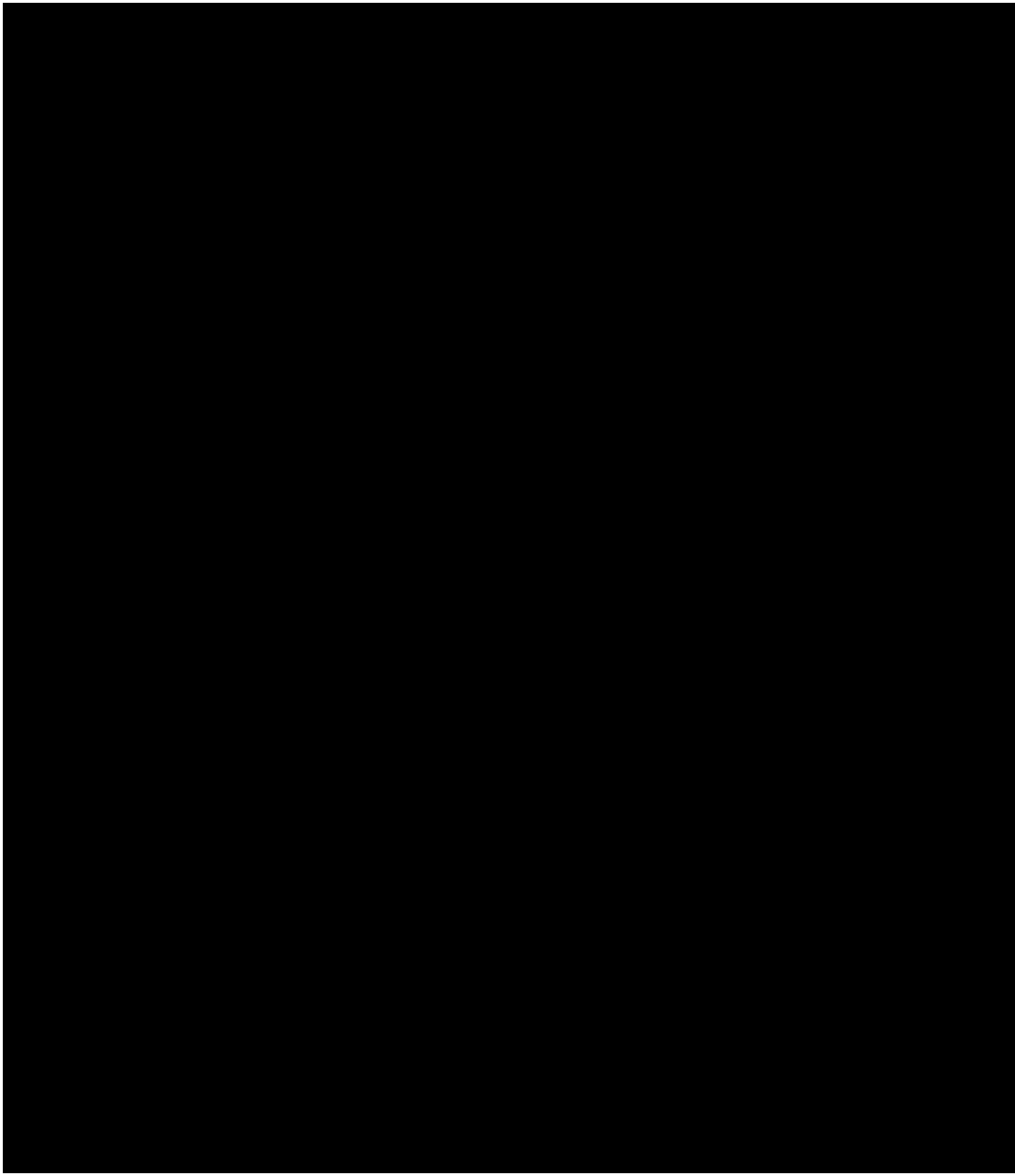


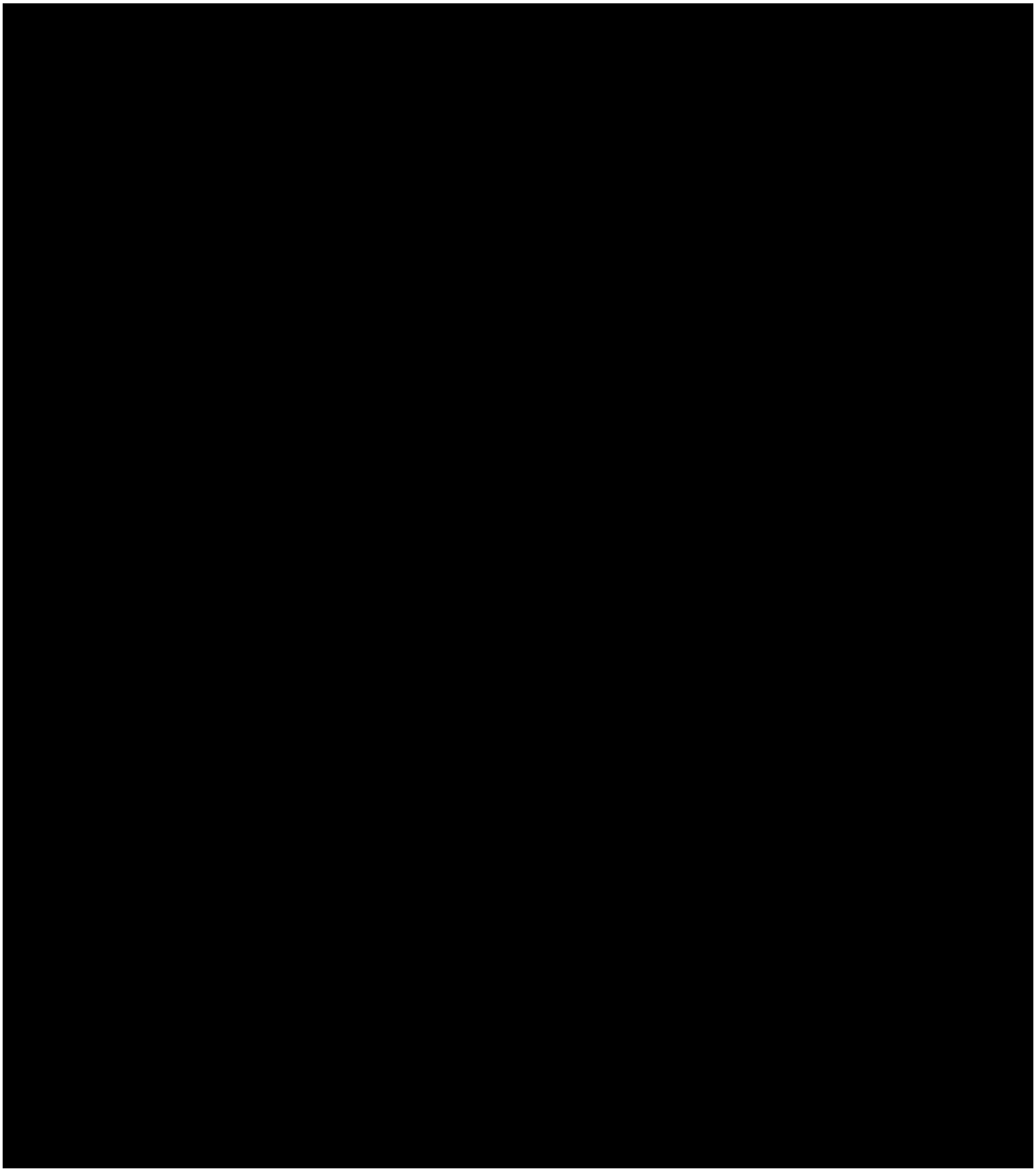


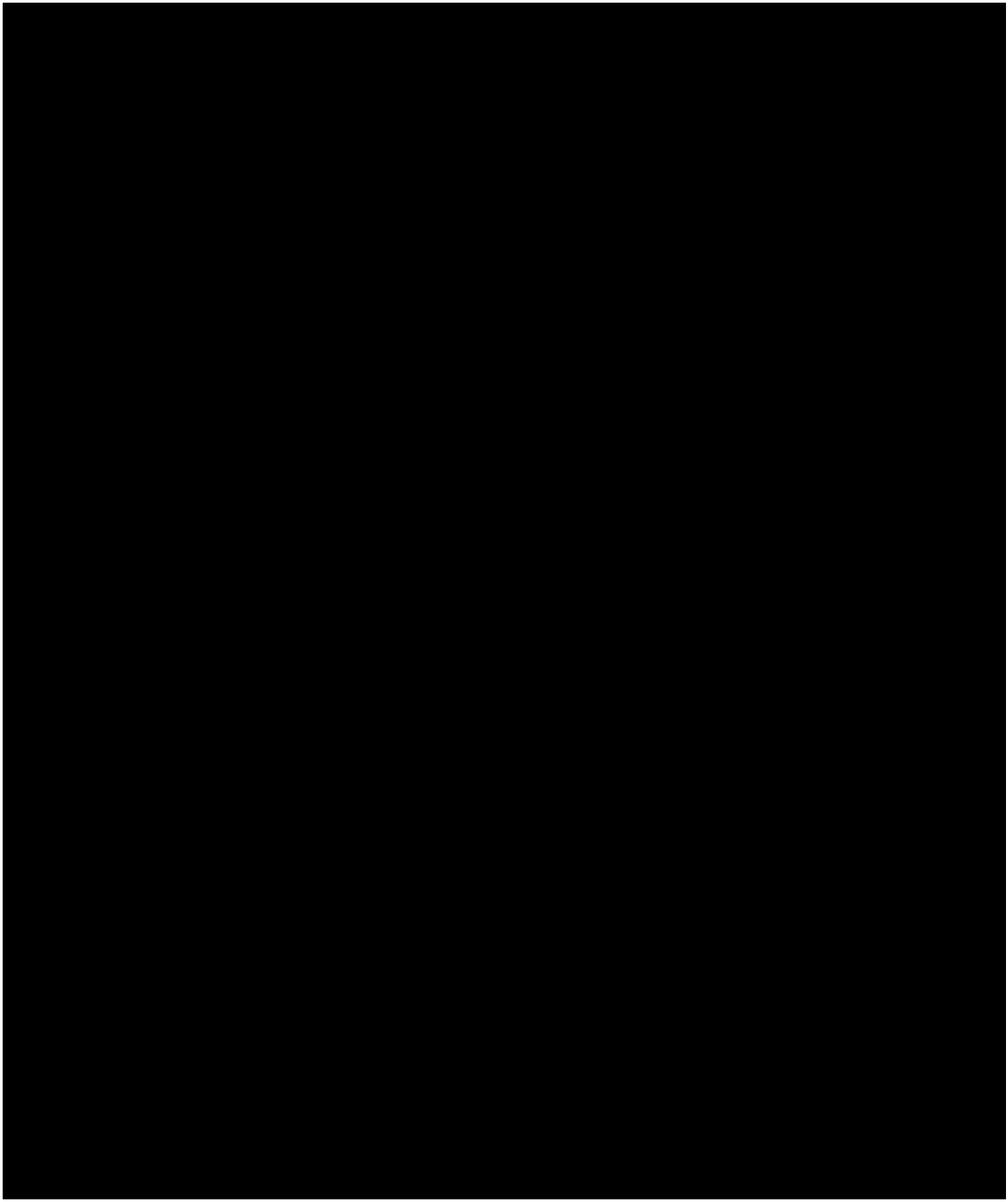


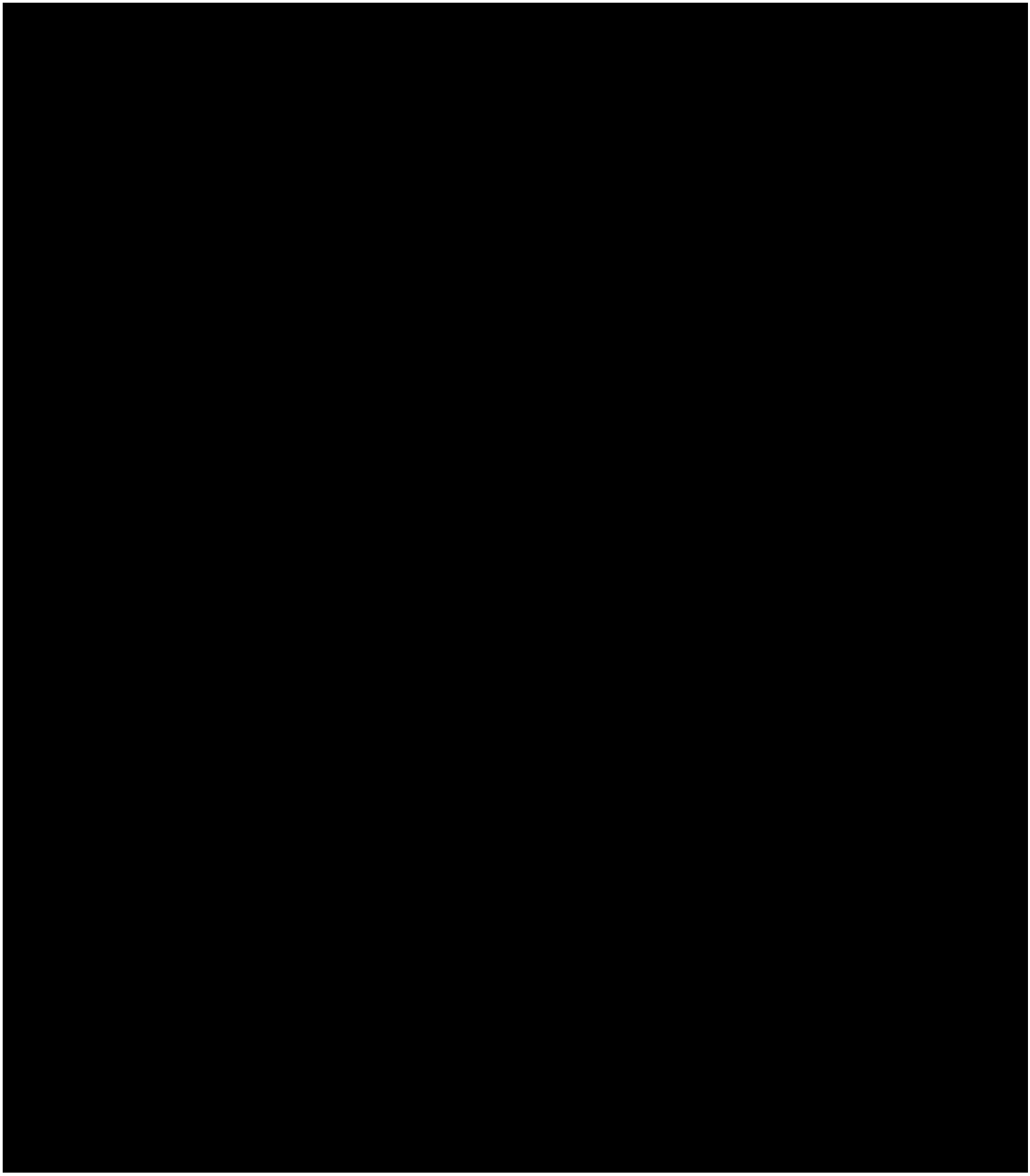


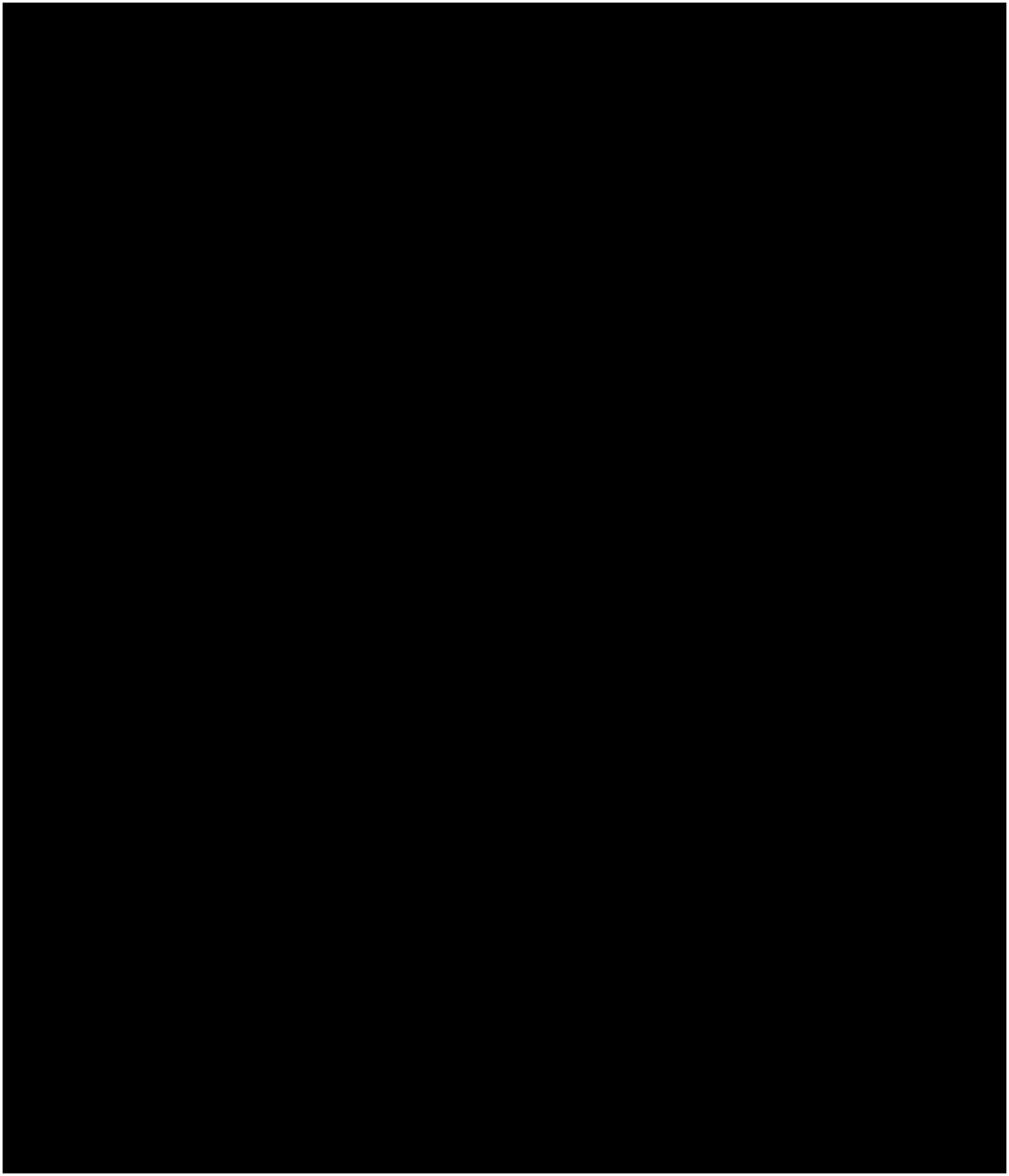


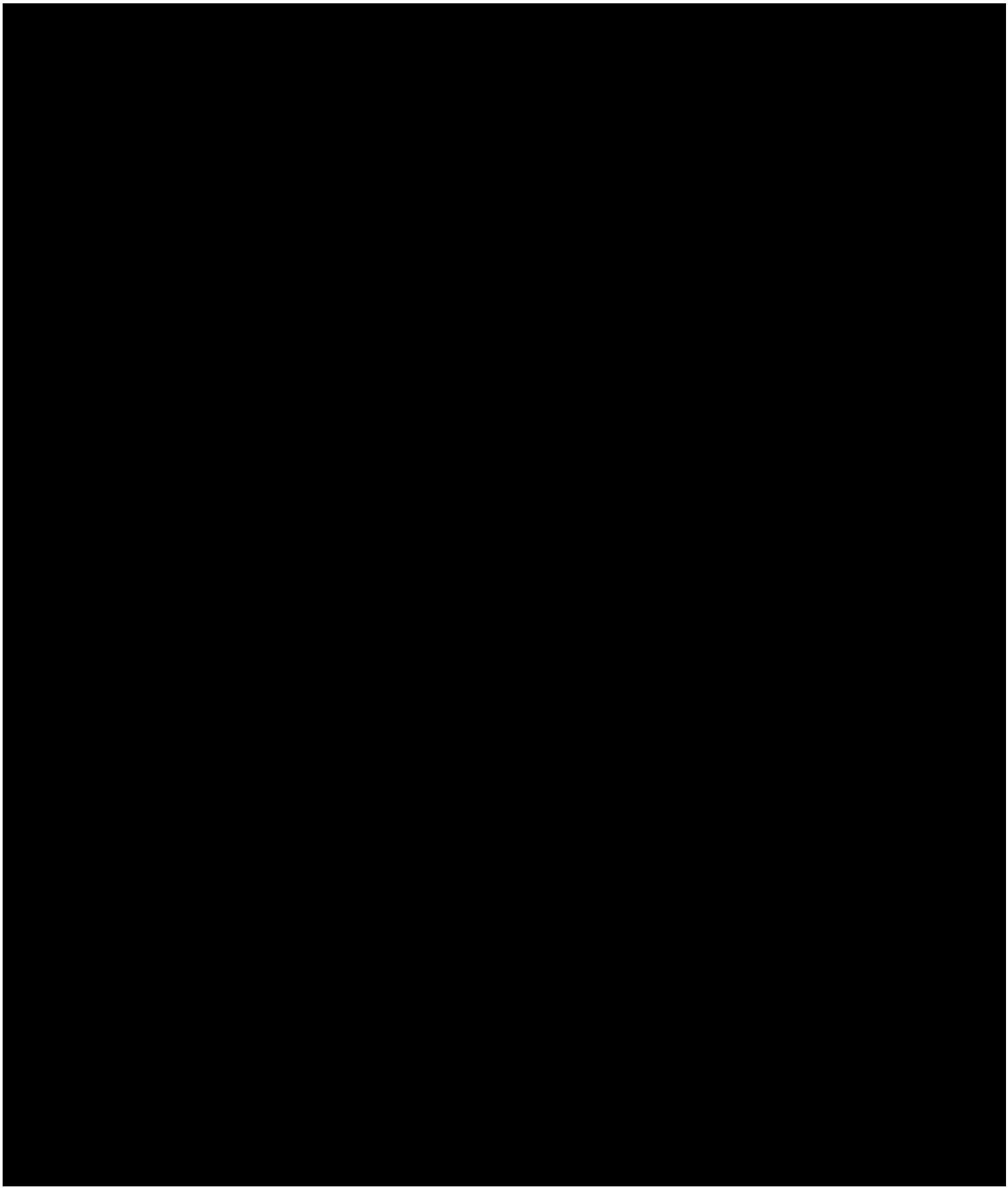


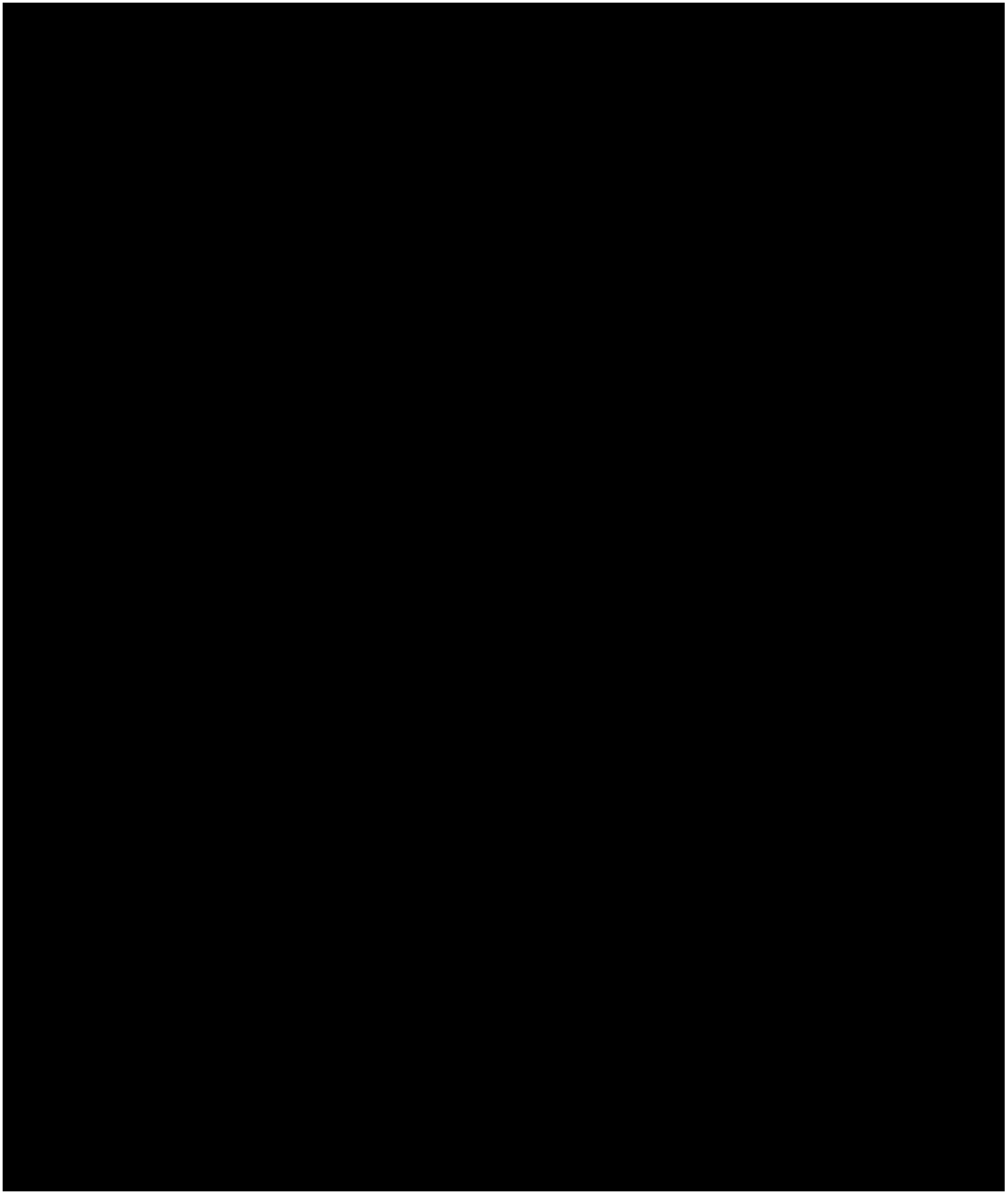


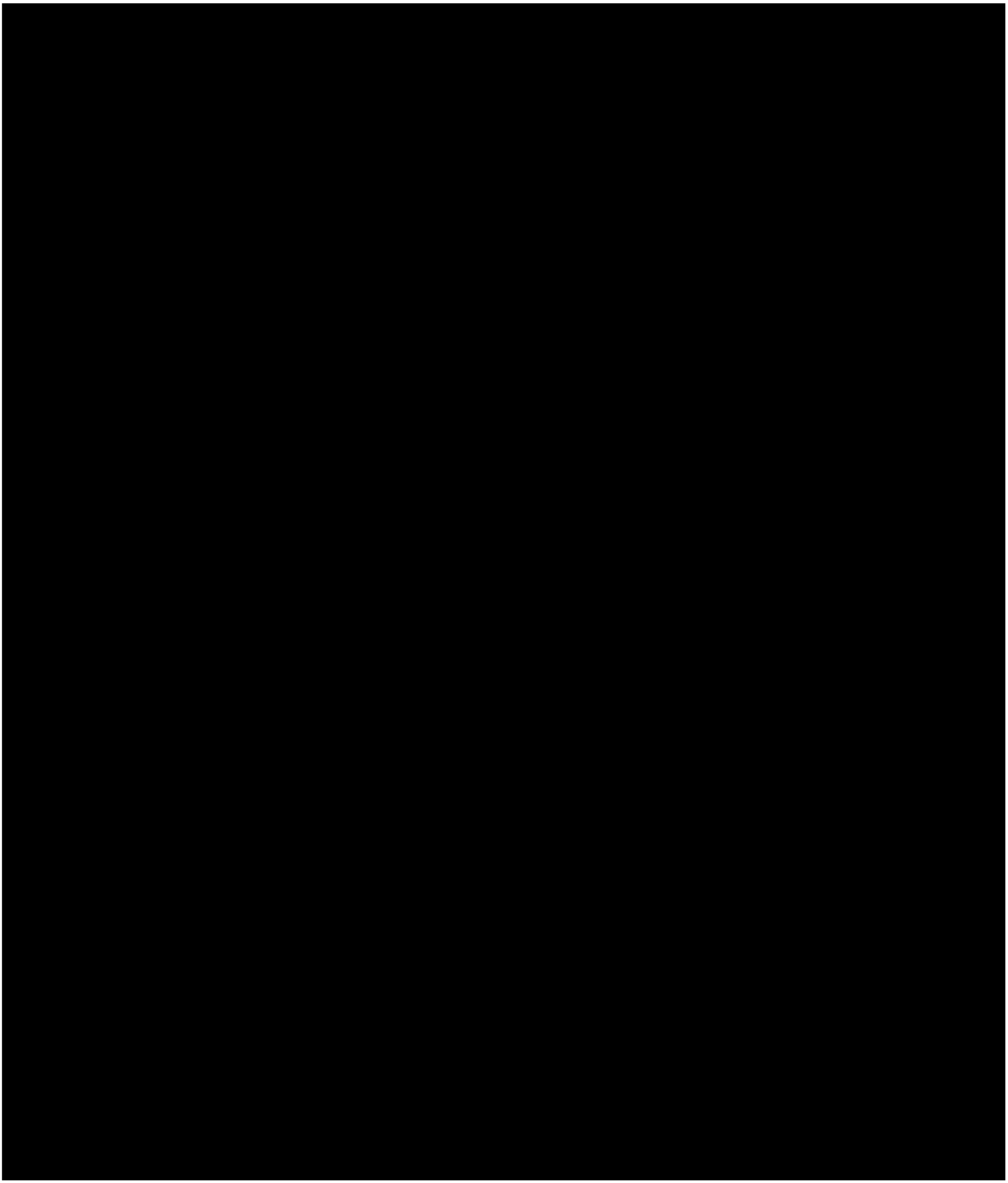


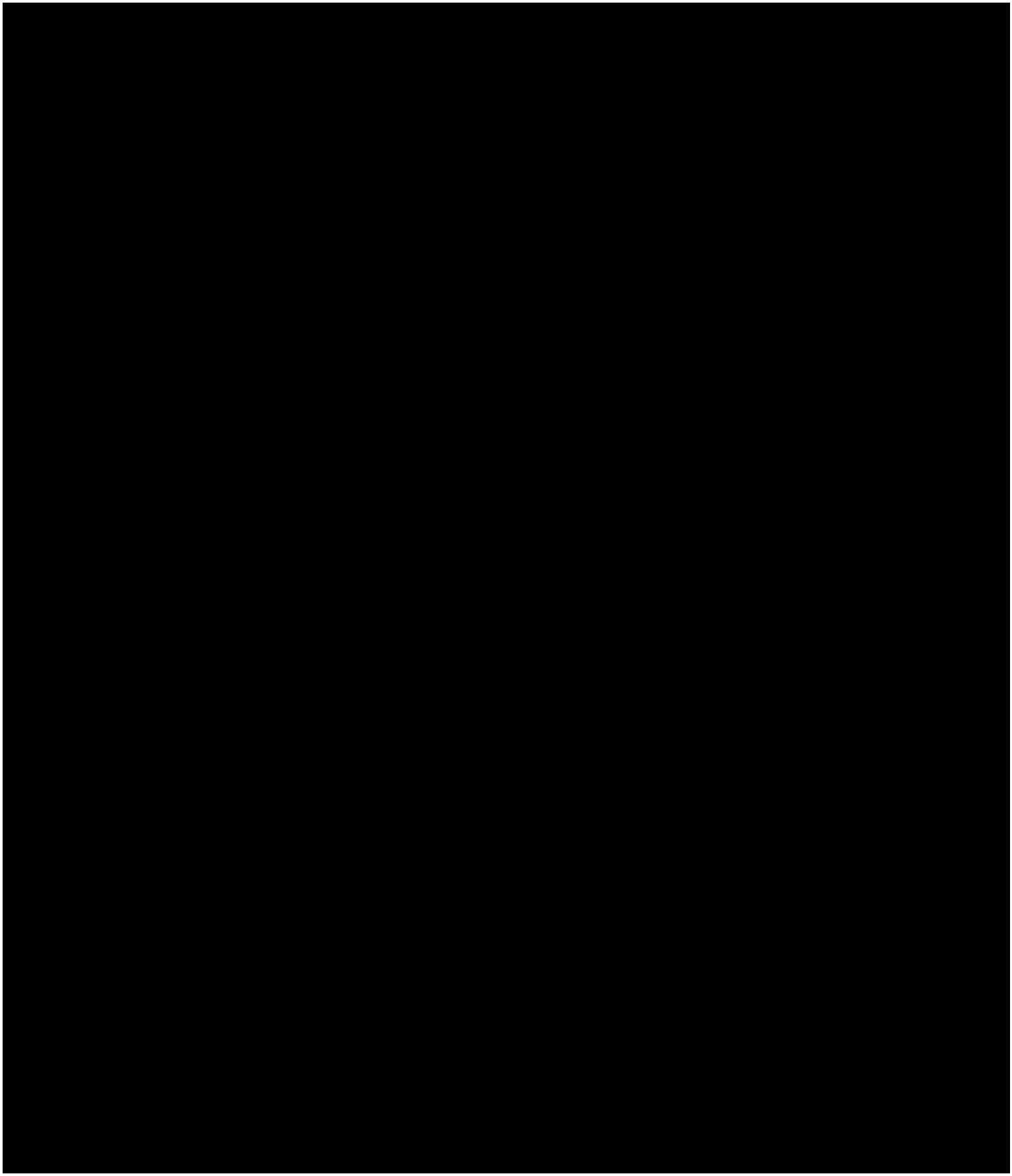












RFP 112209 O3

B. Technical Approach

V.S Claims Management

V.S Claims Management

104. Describe the Bidder's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the Bidder's strategy for identifying problem areas, and how the Bidder will ensure rapid response. ***Page Limit: 2 (Per Addendum 3, Q&A #25 attachments are not included in the page limit)***

Strategies for Successful Claims Processing and Implementation

Since Nebraska Total Care's initial implementation in 2017, we have continued to improve our claims processing strategies, expertise, configuration, and tools to achieve operational excellence. Nebraska Total Care began processing claims on behalf of over 82,800 Medicaid members including adults, children, seniors, and individuals with special needs, and now manages claims operations to support over 120,000 Medicaid members. As our claims processing grew from just under 2 million in 2019 to over 2.4 million in 2021 our claims turnaround time (TAT) for medical and behavioral health claims continues to exceed operational targets with TAT averaging 99% or higher as noted in **Table 104**. We are prepared to begin processing dental claims through our partnership with our affiliate Envolve Dental and will apply the same level of operational excellence for this additional benefit. We will continue to provide claims processing and adjudication services for drugs covered under the drug benefit with our established Pharmacy Benefit Manager, vision claims processing with our affiliate vision vendor (Envolve Vision), and NEMT claims through our transportation vendor.

Table 104 Claims Processing TAT and Growth

Claims Turnaround Time (TAT)*			Claims Processing Growth	
	10 Day	60 Day		
2019	99.07%	99.81%	2019	1,978,974
2020	98.88%	99.67%	2020	1,820,578*
2021	99.06%	99.77%	2021	2,419,655
* Medical and BH Claims			*Decrease Due to COVID	

Implementation Strategy Assures Readiness. Our Enterprise Business Implementation (EBI) and IT Implementation Teams use tools and templates tailored to meet the needs of Medicaid managed care projects, including lessons learned from the experience of our 2017 Nebraska Total Care implementation. The EBI Team uses a strategy that encompasses the following key areas: project scope, project communications, resource planning, work plan and schedule, risk management, quality control, and cost management. We tailor each template to meet new Contract requirements while leveraging Centene's enterprise best practices. Our project management approach and strategy consist of these five key elements: 1) consistent project lifecycle methodology, 2) dedicated, local, and highly specialized professionals, 3) customized communications plan, 4) proprietary tools for tracking deliverables and owners, and 5) proactive systematic monitoring of implementation progress, issue identification/analysis, and resolution. By carefully managing communications, we ensure all stakeholders understand exactly what needs to be delivered, the scope of work required, and who to contact to obtain needed information including project status or information needed to resolve problems. Our EBI Team uses a best practice framework for planning, organizing, communicating, and mobilizing resources to ensure smooth, low-risk, and on-time implementations.

"We have been very pleased to work with Nebraska Total Care the last several years. Not only are they advocates for their members, but they are also great advocates for the providers in which their patients are being seen. Whenever we have a payment or claim issue, they are quick to respond to help us find a solution. All their provider representatives, contract managers, and other staff we have been in contact with over the years have been excellent resources and deliver great customer service."

- Dayle Harlow – Chief Revenue Officer, Fillmore County Hospital

Implementation Staff Expertise. Our Claims Implementation Team uses pre-populated templates; carefully defined checklists, configuration procedures, and project communications (both internal and external) to support readiness, configuration, and test activities for claims eligibility, benefit plan, and adjudication rules. Claims Processing and System Configuration Implementation Teams are dedicated to a successful implementation and meeting MLTC established goals. The staff in our Claims Operations division have an average of 19+ years of claims experience per processor, including extensive readiness and implementation experience. Our IT Implementation Team is comprised of experienced IT Program Managers to support Nebraska Total Care's Project Implementation Team. Before the contract go-live, a dedicated IT Program Manager serves as a liaison between our centralized IT resources and local Nebraska Total Care staff to help facilitate and coordinate deploying any new system configurations and processes across all functional areas, for example, enrollment, contracting, member and provider services, claims and encounters, and data and analytics. We have demonstrated the effectiveness of our management teams and local staff through our continuous operational improvement since 2017, and by the partnerships, we have built and maintained with our members, MLTC, providers,

community advocates, and stakeholders. ***Our annual Provider Satisfaction Survey Review Scores improved by 10% from 2019 to 2021*** (up to 83%) when providers were asked about satisfaction with the claim's payment process from claim submission through adjudication.

Contract Notification. Notification of the contract award will initiate the Project Implementation Phase activities. However, if Nebraska Total Care needs to support aggressive MLTC implementation timelines, certain activities may begin before Contract award or finalization. This period includes all activities required to ensure effective implementation in alignment with the timing for the enrollment of members.

Technology for Claims Processing Success. Our MIS configuration utilities minimize, if not eliminate, the need for custom software development. This reduces implementation risk while meeting the specific rules and processing needs of Nebraska Total Care. Our Claims Processing System, along with our HIPAA EDI infrastructure and Claims Workflow Management systems are configured with the claims requirements and timeframes mandated by MLTC to meet any new contract requirements and Federal regulations. Our Claims Processing System employs multiple, systematic data edits to ensure claim processing accuracy and a high claim auto-adjudication rate. Our Claims Processing System delivers accurate claims payment, with configuration capabilities to price according to benefit coverage information, authorization requirements, fee schedules, per diem rates, capitation payments, and other complex pricing arrangements. We continuously meet our internal goal of a claims payment financial accuracy rate of 99% annually.

Claims Financial Accuracy

Nebraska Total Care claims financial accuracy has remained at 99% annually for the past 3 years (2019 - 2021).

Pre-adjudication Edits. Our MIS uses a standard-based Service Oriented Architecture (SOA) with middleware that maps translates and validates claims data against member and provider information data in our MIS before adjudication, ensuring common edits, such as member, billing, and rendering provider identifiers are applied. If a transaction is rejected, our middleware issues an ANSI 277 Unsolicited notification citing the specific MLTC-approved reason(s) responsible. In the event a paper claim fails pre-adjudication edits, our middleware automatically generates and sends a letter to the submitting provider, rejecting the claim and citing the specific edit(s) responsible.

Claims Processing System. Once claims pass the above edits and validation routines, our Claims Processing System translates claims data for adjudication through a combination of edits examining diagnosis and procedure codes including HCPCS data, Medicaid Correct Coding Initiative edits, and use and validation of National Provider Indicator (NPI), State Medicaid Identifiers, and tax ID numbers for provider payment. Our ClaimsXten software reviews adjudicated claims before payment for bundling and unbundling of services, incidental services, mutually exclusive codes, global surgery follow-up days, duplicate claims, invalid procedures, bilateral services, and incorrect age/gender validation.

Configuration Testing. All configuration changes go through a comprehensive testing process as part of our EBI Model strategy. Changes are configured in our development environment before being promoted to the testing environment for integrated and regression tests. This enables us to anticipate significant processing scenarios before go-live. Issues are immediately communicated to the configuration team. Once resolved, the configuration moves back to integrated testing. Upon successful integration testing, the configuration moves to user acceptance testing (UAT). In UAT, the tester reviews the integrated testing results, runs real-life scenarios through the system, and reviews results for accuracy. At least 30 days before go-live, the claims operations and IT staff will jointly test hundreds of claim scenarios using test claims with actual MLTC data. Joint meetings are conducted with staff from the claims implementation, contracting, configuration, and provider data management implementation teams. During implementation, we share claims submission and adjudication testing results with providers to ensure reimbursement aligns with expectations.

Monitor Continuous Improvement and Direct Rapid Response. Using our Centelligence reporting and analytics platform we gain insights into our claims operations. Centelligence captures data from our Claims Processing System and provides an end-to-end view of claims processing for monitoring and reporting potential issues. Our Claims Manager uses Centelligence to track rejected claims through our Business Operations Claims Dashboard. Using the Business Operations Claims Dashboard, the Claims Manager can monitor error trends or potential system issues and share them with the appropriate business area team for remediation. Through Centelligence, we are readily equipped to identify, isolate, and rapidly respond to problem areas. Each department and the implementation teams have access to utilize these reports to identify root causes and impacted functional areas upstream or downstream for efficient, effective resolution by the Nebraska Total Care Claims Team. We coordinate expertise from each area, including analyses from our Claims Liaisons and Contract Implementation team, Encounter Business Operations, Finance, Compliance, Provider Relations, and subcontracted vendors to collaboratively provide creative, comprehensive, and innovative solutions with effective, accurate, and efficient claims processing for our provider network and MLTC.

105. Describe the Bidder's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address:

- *The process for auditing claims samples.*
- *Documentation of the results of these audits.*
- *The processes for implementing any necessary corrective actions resulting from the audit.*

Page Limit: 3

Nebraska Total Care will continue to achieve high standards of claims payment accuracy through a combination of regular, formal quality reviews, independently performed internal and external audits and best practice oversight and governance of our subcontractors. We will continue to comply with all RFP requirements, including those outlined in sections V.S.9 (Claims Payment Accuracy) and V.S.13 (Audit Requirements) within the Scope of Work (SOW), which includes coordinating audits with MLTC as necessary, submission of claims payment accuracy reports and responding within the timeframes and under existing State and Federal regulations. Our affiliates comply with similar best practices, and comprehensive audit procedures across several of the states where Centene subsidiaries operate Managed Medicaid plans today.

Accuracy Standards and Goals

Nebraska Total Care adheres to corporate standards for claims payment accuracy developed through continuous market research within our full scope of Managed Medicaid Affiliates, as well as comparative MCOs. We track and measure results to these standards (99% Financial Accuracy goal) and report results monthly to MLTC on claims accuracy outcomes and remediation steps and status for self-identified processing errors, as needed.

Accuracy Achievement

Nebraska Total Care has achieved ***99% annual financial accuracy of claims adjudicated*** for the past three years.

Audit Methodology to Ensure Accuracy

Centene's Internal Audit Department (IAD) is independent of Nebraska Total Care's Claims Department and is led by a Chief Audit Executive (CAE). IAD includes a Claims Audit Division (CAD) that is responsible for providing an independent and objective evaluation of claims payment accuracy per the Nebraska Total Care policies and procedures. CAD helps ensure that provider payment processing is per appropriate rates and that all State and Federal claim processing rules are followed. CAD audits encompass claim entry, adjudication, and whether determinations on benefits and payment are accurate. CAD reports audit results through regular monthly status updates and claims quality dashboard reports. Monthly, Nebraska Total Care submits claims payment accuracy percentage reports to MLTC. CAD's independence enables unbiased, objective evaluations of the staff and the system configuration and functionality.

Claims Sampling. Our CAD staff performs statistically valid audits based on a random sample from all first-time submissions of adjudicated electronic and paper claims as outlined in Section V.S.9.c of the SOW. Financially stratified random samples are selected from each check run weekly, which includes all paid, denied, appealed, and adjusted claims. CAD uses a sample size calculator from the Office of the Inspector General (OIG) website to determine the total sample size and allocation to each financial bucket or strata. The assumptions are based on a 99% confidence level, plus or minus 2.5% to 3% (quarterly); this results in an annual precision range of +/- 1.5%. The CAD staff then divides the total quarterly sample size to each week within the quarter on an even proportion basis, from which, an automated program randomly selects claims from the claims paid tables according to each strata guideline. Dollar stratification allows CAD to test the various controls within the claims adjudication system and manual workflow streams.

Audit Process. CAD audits each claim from the sample extract of finalized claims processed from initial claim submissions. Claims are stratified into financial quartiles allowing us to isolate different systemic factors and functions. When reviewing the claims sample, CAD staff review factors such as whether the claim was entered correctly, whether the claim was associated with the correct provider, whether proper authorization was obtained for the service (if required), and all additional attributes described in Section V.S.9.d These audit processes involve validating the six steps of adjudication to primary source documents and manually repricing the product independently from the claim system; such factors include, but are not limited to: validating reimbursement to applicable executed contract; validating coinsurance/copays to the applicable summary of benefits and tying out applicable rates to fee schedules on State/Federal websites.

Our CAD staff documents the audit results for each attribute reviewed in our claim audit software. When an error is found, we document the specific error reason and if applicable, the dollar amount incorrectly processed for both over payments and underpayments. CAD staff communicate errors in real-time back to the responsible department and is responsible for facilitating, tracking, and reporting the status of corrective actions and management's assessment of the root cause. For verification purposes, CAD maintains records of the population of claims used in the audits. Accuracy scores are continually updated via an internal dashboard, and summarized results are shared monthly with the local Nebraska Total Care Claims Manager and other leadership as appropriate. The Claims Manager reviews the monthly summarized audit results and

identifies action steps for any errors identified, reviews for any systemic issues, and ensures appropriate remediation actions are identified and completed at all levels to implement solutions. This includes, but is not limited to, oversight and completion of staff re-training, submission, and tracking to completion of system change requests, submission of provider data updates, and review and revision of claims processing workflows. The Claims Manager also has the option for an internal appeal, if needed, to resolve disagreements on cited errors.

Audit Documentation. As claim audits are complete, any identified claims compliance issues are documented in our Compliance Management System. This system allows Nebraska Total Care to systematically track compliance activities (with auditable records of management approval) and effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight responsibilities. The Compliance Management System also enables workflow routing per policy and procedure formulation (with history of documentation and sign-offs), and allows ongoing, proactive assessment of compliance risk. It also enables us to route action items to the appropriate internal departments and subcontractors for follow-up. We track and monitor the status of corrective actions, following issues through to resolution.

Corrective Action Plan. All audit reports are reviewed by coordinated expertise from internal department leads, to provide comprehensive and innovative solutions for ongoing effective, accurate, and efficient claims processing for our provider network. The Corrective Action Plan Process includes four steps to avoid repeat errors:

- **Fix the Claim.** Fixing the claim and ensuring accountability and traceability is the first step in the process. Determination is then made on whether a claim project, to correct additional claims, is needed. Upon identification of a potential systemic process deficiency**,** we collaborate across internal departments to determine the root cause. Through cross-functional dialogue with all affected departments, we evaluate and recommend process improvement plans, retraining needs, or configuration updates.
- **Fix the System**. When a configuration update or other system change is required, a traceable ticket is opened to assign accountability and resolution.
- **Collateral Impact.** Further research is conducted to determine if any further claim corrections or system updates need to be completed due to the impact of the initial error.
- **Prevention.** Assessment is conducted on what could be done along the process to control the error. Updates to procedures or retraining are done as necessary and drive actionable behavior to implement ongoing corrective methods.

Subcontractor Audits

Our Compliance Department monitors subcontractor performance (including encounter submissions) formally through quarterly Vendor Oversight Committee (VOC) operational reviews with each subcontractor. Subcontractor VOCs will include executive and operational staff from Nebraska Total Care, Centene, and the Subcontractor. The VOC monitors all functions delegated to the subcontractor. The VOC also helps facilitate health plan - Subcontractor partnerships, encouraging operational efficiencies, and delivering support to our subcontractors. We will submit a monthly claims payment accuracy report for claims processed by our subcontractors as defined in Section V.S.9.f of the SOW. The audit will review and report on the same attributes as those listed in section V.S.9.d of the SOW. In addition, we perform an annual subcontractor delegation audit related to claims and encounter administration. Audits will be conducted using predetermined audit tools that incorporate contractual, NCQA, CMS, and MLTC requirements.

Corrective Action. Through the VOC, we will monitor our subcontractors to ensure that any material audit findings are addressed by the subcontractor with any of their staff or affected providers.

Notice to Cure. If an issue is identified that is trending towards performance noncompliance, it is documented in writing and sent to the subcontractor requesting an explanation and cure within 30 calendar days. The copy of the Notice to Cure is stored in the Compliance Management System as evidence of the notification. The subcontractor has three business days to respond as to the root cause of the deficiency and the action that will be taken. An evaluation of the deficiency resolution will be completed in 30 calendar days; otherwise, the issue will be elevated to a Corrective Action Plan (CAP).

Corrective Action Plan (CAP). If a CAP is necessary, based on continued trending towards non-compliance or as the result of an audit, it is outlined documenting the root cause and what has triggered the creation. A copy of the CAP is stored in the Compliance Management System as evidence of the notification. Actions are expected to be remediated within 30, 60, or 90 days depending upon the nature of the issue. An evaluation of the deficiency resolution will be completed at the end of the documented remediation period. If resolved, written notification is provided to the subcontractor, and a copy of the closure notification is stored in the Compliance Management System. If the deficiency is not resolved, Nebraska Total Care's Vendor Manager meets with the subcontractor to understand the challenges and/or barriers to a timely resolution to determine the appropriate next course of action. The Vendor Manager determines if a penalty will be invoked and contacts the appropriate Controller with evidence and a decision to invoke a penalty. The subcontractor is notified in writing per

Contract requirements before invoking the penalty, and the Controller facilitates the settlement of the penalty.

Opportunities for Improvement (OFI). As a best practice, Nebraska Total Care tracks observations of potential compliance issues and/or concerns noted during an audit, which are referred to as Opportunities for Improvement (OFI). These items do not require formal corrective action at the time of issuance but are monitored by the subcontractor to ensure they do not become significant risks. Nebraska Total Care may initiate remedial action if specific instances of noncompliance are identified later. The status of OFIs will be evaluated during the next audit period, not to exceed two years.

External Audits

Nebraska Total Care complies with the requirements outlined in Section V.S.13.a.i of the SOW and will continue to provide to any state auditor (including the Auditor of Public Accounts), or their designee, files for any specified accounting period for which a valid contract exists, in a file format or audit defined media required by the auditor. If the auditor's findings point to discrepancies or errors, the Nebraska Total Care will provide a written corrective action plan to MLTC within ten (10) business days of receipt of the audit report.

Post Audit Activities

Education and Retraining. Claims processing issues related to claims staff performance or provider billing errors are typically remediated through education and retraining. CAD staff communicates all staff deficiencies to the Claims Manager who establishes a retraining plan. After retraining, the Claims Manager may implement a targeted audit to confirm that additional training or action is not warranted. CAD Staff communicates all provider billing problems to Nebraska Total Care's Provider Relations Department where outreach and education can be arranged and conducted by their Provider Relations Representative who uses specific examples and documentation, such as our Provider Billing Guide, to support provider education.

Configuration Change. If an audit finds that the error is due to configuration, our Nebraska Total Care Business Analyst and our Configuration team review the logic causing the error and file a detailed Configuration Request (CR) to have the configuration updated. All CRs go through our standard, best practice change management regimen, with testing and validation that the correct outcome was achieved, followed by User Acceptance Testing (UAT). After successful UAT, the change is promoted to production.

Expedited Corrective Action

Through our internal claims audit, we proactively identified that Nebraska Total Care had not set up one of the Assistant Surgeon (AS) Modifiers to mirror processing methodology of the other AS modifier (80). Configuration updates were made swiftly to align the AS and 80 modifiers to enable claims to auto-adjudicate accurately and provider notification completed.

Reducing Administrative Burden for our Providers

Accurate claims processing and prompt payment are key to provider satisfaction. We train providers on claims policies and procedures initially at orientation and at least quarterly via town halls, as well as through provider news on the Nebraska Total Care website, and via bi-weekly provider newsletters. Providers find support for claims at every touchpoint: In the Provider and Billing Manuals, online, telephonically through the Provider Call Center and hands-on via the assigned Provider Relations staff. We also identify providers who balance bill inappropriately (beyond any required cost-sharing) and provide needed support to resolve member billing concerns.

Billing Issues and Targeted Outreach. Our audit activities allow early identification of possible billing issues. When issues are identified, Nebraska Total Care staff works with providers directly to educate them via phone calls and during onsite visits. If trend analysis identifies a provider who is failing to adhere to billing requirements, the Provider Relations Staff refer their findings to Nebraska Total Care's Provider Network Team for action. A PSR from the Provider Network Team immediately contacts the provider, provides education on contractual requirements, and offers the local Nebraska Total Care Claims Team, or other responsible departments to conduct retraining. The Nebraska Total Care staff document all activities and monitor subsequent performance. For continued billing issues, the Provider Network Team refers the provider to the Credentialing Committee and Provider and Clinical Advisory Committees for additional action, including sanctions and possible consideration of continued network status.

Reporting to MLTC

Accuracy statistics are currently reported to MLTC monthly through the Monthly Payment Accuracy Report. As outlined in Section V.S.9.a of the SOW, Nebraska Total Care can submit Claims Payment Accuracy Reports to MLTC quarterly and the report would be based on the audit conducted by the CAD, outlined earlier in this response (V.S.9.b). Nebraska Total Care has the infrastructure and staff in place to support the claims audit reporting needs of MLTC, whether they are standard, scheduled reports, or ad hoc requests, including provider sanction requirements.

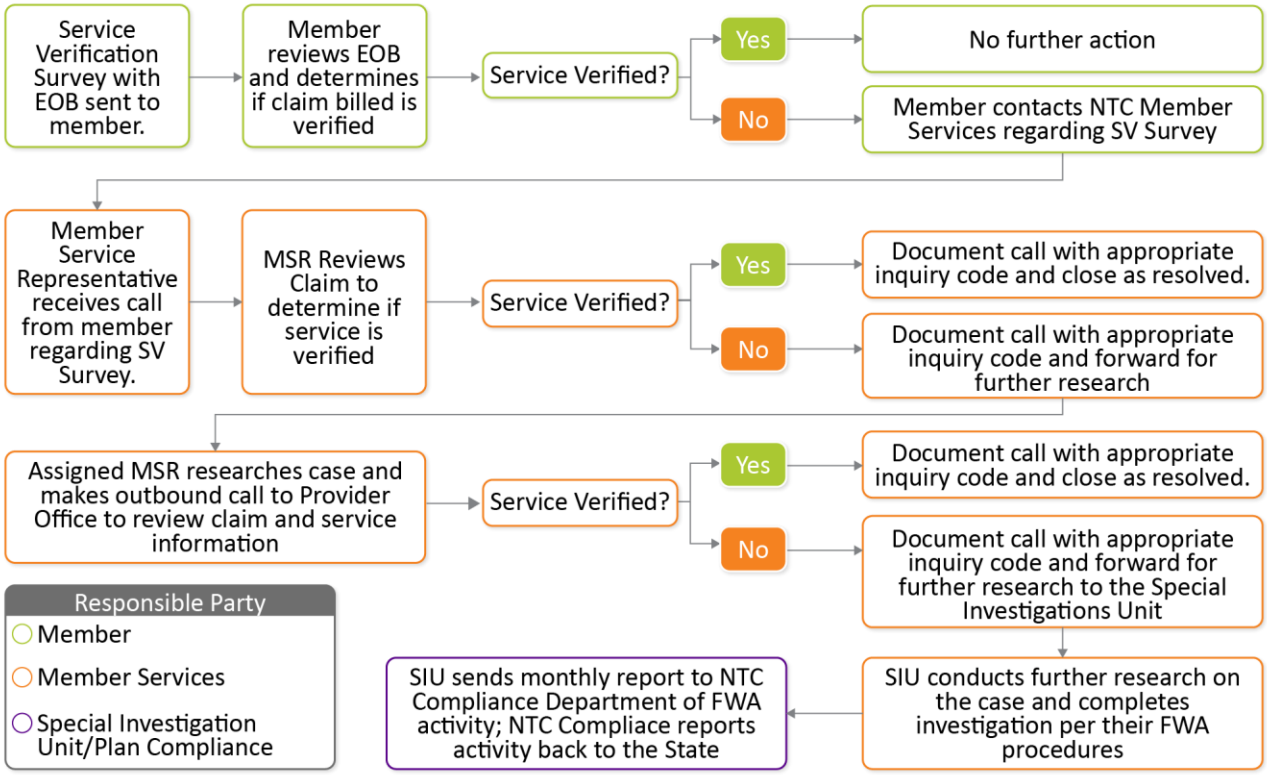
106. Describe in detail how the Bidder will verify that services were actually provided including:
• Minimum sampling criteria to ensure a representative sample.
• How results of monitoring will be reported to MLTC quarterly.
Page Limit: 3

Nebraska Total Care is committed to the integrity of Nebraska's Medicaid program and has demonstrated effective management of public resources in service delivery to Medicaid enrollees and providers since program inception. We are committed to the Nebraska Medicaid Program Integrity Unit's (NMPI) goal of preventing, detecting, reporting, and reducing Fraud, Waste, and Abuse (FWA). Our philosophy is that all Nebraska Total Care employees, providers, subcontractors, and enrollees have responsibility for program integrity, including identification and reporting of potential FWA.

Service Verification Process

Nebraska Total Care, using our enterprise Management Information System (MIS) in conjunction with Centene's Payment Integrity Department, has implemented best-practice processes, including member service verification surveys, to verify services provided to our members. We administer these surveys in coordination with complementary controls to identify and act on instances of suspected FWA. Included below in **Figure 106** is a high-level overview of the Service Verification Process.

Figure 106 Service Verification Process Overview



Member Engagement Through Validation of Paid Claims. We partner with members using a service verification (SV) process to determine if specific services were provided as part of our efforts to prevent FWA. We mail an Explanation of Benefits (EOB) and SV survey to a random sample of members, reflective of all provider types and billed services of our member population. We mail the EOB to the member within 45 days from the payment date containing billed claim information specific to the member. We ask the member to sign and return the SV Survey to our office. If a member did not receive the services, we request that they contact Member Services directly.

Proven EOB Survey Approach in Use Today. Nebraska Total Care uses a survey approach, customized per MLTC's specific requirements in Section V.S.7.a., and in compliance with 42 CFR 455.20 and 433.116(e). The process is based on the strategy employed by many of our affiliates operating Managed Medicaid programs today in 20 states, in which our affiliates randomly select a stratified sample of claims monthly, to send an Explanation of Benefits (EOB) statement along with survey instructions to the member requesting service verification. Specifically, Nebraska Total Care's Information

Systems Department will initiate the claim sampling and forward the selected claims to the Output Center for printing and mailing of the individual surveys and the EOBs. Per 42 § CFR 433.116, the member SVs for the health plan will include the following information documented at a 6th-grade reading level:

- A description of services provided and billed to the health plan
- The name of the provider furnishing the service
- The date on which the service was furnished
- The amount of the payment made under the plan for the service

Service Verification Surveys

On average, Nebraska Total Care mails 2,300 Service Verification surveys and accompanying EOBs per month.

Sample Selection Process

Sampling to Ensure Representative Claims in Member Surveys. Our sampling methodology assures that our member survey samples proportionately reflect billed services for the overall member population so that we can monitor our entire program with statistical confidence. Per the requirements outlined in Section V.S.7.b of the Scope of Work, we randomly sample data from our Centelligence informatics platform to select a claims sample size of no less than 2% of claims processed per month, of claims paid in the previous 45 calendar day period (as mandated by Federal regulation). Nebraska Total Care claims sampling stratifies the selection based on dollar figure amounts as listed:

- $0 - $999.99
- $1,000 - $9,999.99
- $10,000 - $49,999.99
- $50,000 or greater

Acting on Survey Results. Survey results are captured by mail, telephonically, or in person (for example, during a case management on-site visit). In compliance with Section V.S.7.e. of the Scope of Work, when members respond to our survey to tell us that they have not received the service(s) listed on the EOB, our Member Service Representatives (MSRs) capture that information in the Customer Relationship Management (CRM) component of our MIS. MSRs then forward the information to the Nebraska Total Care Compliance Director (who has the role of our Program Integrity Officer) for further review. Upon suspicion of fraud, we forward suspected cases to the MLTC Program Integrity Contact within three business days. As necessary, our Compliance Director will also engage FWA investigative staff in our Special Investigation Unit (SIU), part of our Payment Integrity Department. The SIU will conduct a preliminary investigation and, if needed, submit additional requests for member surveys via telephone. Our call center and the Corporate Special Investigation Unit maintain Nebraska Total Care-specific policies and procedures when a member responds to one of the Service Verification Surveys. The SIU provides monthly reports to the Nebraska Total Care Compliance Department of all relevant activities.

If the member responds to the survey noting that the service is verified, the MSR documents the call in the CRM system noting the call as a service verification. If the member wants to file a complaint about the service not being verified, an experienced MSR follows up with the provider for additional information before sending the case to the SIU for further investigation. The issue is documented as a formal grievance per the Nebraska Total Care policy, and required resolution may be member or provider education, payment recovery, or referral for further investigation to MLTC.

Reporting Quarterly Results

Technology Powered Data Integration. Nebraska Total Care uses Centelligence, the reporting component of our MIS, to produce required reports for MLTC. Centelligence is our integrated data warehousing, decision support, and health care reporting solutions. Centelligence provides comprehensive business intelligence support, including flexible desktop reporting and online dashboards with drill-down capability. We track which members have received surveys, and through our CRM, members have notified us of concerns or complaints related to our survey or potential FWA. This information comes together in Centelligence.

Supporting MLTC's Reporting Needs. The Nebraska Total Care Compliance Director reports service verification activities quarterly, per Attachment 13 and Section V.S.7.f. of the Scope of Work, to the NMPI Unit. Reports include the total number of survey notices sent out to members, the number of surveys completed, the total number of services requested for validation, and the number of services validated. Because we use CRM to manage all member complaints, we can also provide an analysis of interventions related to complaints or other service validation issues.

Continued Process Improvement

Figure 106 Service Verification Process Overview and clear Policies and Procedures that have been developed to support this process are due to collaboration between Member Service, SIU, and Compliance to assure we are aligned on functions and responsibilities. Nebraska Total Care strives to evolve, mature, and improve processes for our members and providers to create a better health care experience

107. Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status. ***Page Limit: 2***

Nebraska Total Care's pharmacy program will provide all pharmacy-related technology systems and services through our pharmacy benefits manager (PBM) subcontractor, CVS Caremark (CVS). Nebraska Total Care and CVS work together to configure the pharmacy claims processing platform in compliance with MTLC's Preferred Drug List (PDL) and rebate program requirements.

Pharmacy Drug Reference Database

Industry Recognized Drug Reference Database. CVS' NCPDP D.0-compliant point-of-sale (POS) electronic claims processing system uses **Medi-Span®**, a leading provider of drug information databases, as its clinical reference database and real-time messaging system. Medi-Span continuously draws from updated, comprehensive drug information for prescription and over-the-counter drug products. Our PBM's online, real-time system processes all edits concurrently, including member eligibility, drug coverage, benefit limitations, formulary status, prospective/concurrent drug utilization review edits, and drug rebate eligibility status based on Medicaid guidelines. More than 99% of transactions are processed in less than four-tenths of a second. Claim and encounter history is retained indefinitely, exceeding all current generally accepted retention timeframes, and will be provided on a scheduled basis to MLTC.

Frequent Reference Database Updates. CVS receives daily, weekly, and monthly updates from Medi-Span for various components of their database. Our PBM updates all retail and specialty drug files daily, including all product, packaging, prescription, and pricing information. Updating the drug file begins with an ***automated daily electronic upload*** of data from Medi-Span into the CVS claims processing system. Medi-Span data includes the drug name, strength, therapeutic class, National Drug Code (NDC), Generic Product Identifier (GPI), and pricing measurements such as Average Wholesale Price (AWP) and Wholesale Acquisition Cost. It also includes new-to-market generic and brand name drugs and clinical data to support clinical decisions and POS safety screening. New drugs are added to the current edits daily, according to the drug codes assigned. The Medi-span Medicaid Rebate file is updated and provided weekly and the Drug Interaction file is updated and provided monthly. For all updates, our PBM maintains drug information term dates, obsolete dates, and ongoing rebate status (see discussion below).

Rebates

Supporting MLTCs Rebate Program. CVS' claims processing system reviews the NDC on each claim to ensure the NDC is active in the CMS Drug Products List in the Medicaid Drug Rebate Program. The NDC inclusion status on the CMS Drug Products List is updated quarterly via the Medi-Span file as updates are received. NDCs that are not active in the Medicaid Drug Rebate Program file reject at the POS with pharmacy messaging Non-rebate eligible NDC. ***In 2021, point-of-sale edits for the Medicaid Drug Rebate Program prevented more than 23,000 non-rebate eligible claims from processing, worth a projected cost of nearly $718,000.***

Medicaid Drug Rebate Program labeler code terminations and reinstatements are included in the weekly Medi-Span files that CVS receives. A drug product is designated as Obsolete in our drug file system and, therefore, is no longer eligible for adjudication two years after its Inactive Date, as reported to Medi-Span by the product manufacturer. All drug product records, including those associated with Obsolete products, remain in our drug file system indefinitely.

Pharmacy Encounter Statistics

Nebraska Total Care has demonstrated excellence in pharmacy encounter submission accuracy. ***For the past four years (2018-2021), we have consistently exceeded the 98% QPP Pharmacy Encounter Acceptance Threshold Rate.***

Under the Affordable Care Act and Federal supplemental drug rebate program, CVS submits NCPDP-compliant encounters in claim-level detail to MLTC in the file format and layout determined by the MLTC weekly. The encounters include all attributes in the format as indicated on the Systems Companion Guide, including the Member name, dosage form, strength, package size, and NDC of each covered outpatient drug dispensed for Nebraska Total Care Members, including recognizing claims for drugs purchased through the 340B discount drug program.

Centralized Encounter Processing. Centene's centralized Encounter Business Operations (EBO) Unit defines and establishes best practices in encounter submission processes. The EBO is an agile organization able to learn and share expertise based on variations in requirements across our affiliate health plan operations and the states they serve. The EBO supports CVS and Nebraska Total Cares encounter submissions to MLTC, and Centene's Management Information System (MIS) offers MLTC best-in-class technology that is configurable to meet Nebraska Total Cares specific needs. Nebraska Total Care and CVS continue to assist the State with data, reports, and policy support to ensure their rebate goals are achieved. CVS has direct experience supporting Federal rebates due to States. Designated CVS personnel review and reconcile rebate eligible claims for accuracy before submission to MLTC. Encounters

are sent in NCPDP format from the preceding month no later than the eighth (8th) day of the following month.

PBM Claims Processing System and Drug Reference Database

CVS maintains its proprietary, integrated claims processing suite of systems. Our PBM has complete configuration control over their system, enabling them to make changes to the software based on MLTC's needs. The system is scalable, flexible, and continuously enhanced to keep pace with contractual requirements, enterprise system enhancements, and ever-changing market needs, including State and Federal requirements such as the Medicaid Drug Rebate Program. The current claims processing system, RxClaim, has been operational and continually enhanced since 1995.

System Architecture. CVS invests in state-of-the-art system capabilities. They use IBM's most advanced technology: Power8System model 880 hardware, 64-bit Reduced Instruction Set Computing (RISC) technology for high-speed performance. Redundancy is built into every aspect of the claims processing computer systems. This includes primary and secondary processors for production, a processor for development, and fully redundant disk storage systems. All systems are supported by uninterruptible power supply (UPS) systems and diesel-driven power generators to ensure operations 24 hours a day, seven days a week. Because it is predicated on scalability, our PBM's systems architecture is designed to accommodate significant increases in processing requirements. Our PBM maintains integrated systems with primary functional areas of claims adjudication, data warehousing, and decision support.

RxClaim edits and validates claim transaction submissions for completeness and accuracy per NCPDP D.0 standard, and any future applicable NCPDP format requirements, including, but not limited to, electronic and paper submission of multiple ingredient compound prescriptions, and partial fills. Pharmacy claims adjudicate as specified by applicable benefit plan design requirements including all utilization management edits; current eligibility data; confirmation that the Provider is appropriately credentialed and not excluded; requirements related to Drug Utilization Review (DUR) and prior authorization determinations, including coordinating with Nebraska Total Care systems that support, or relate to, the adjudication function; and requirements of applicable clinical programs, including medical benefits integration programs.

Integrated Claims Adjudication. CVS' system is an integrated pharmacy claims, PA, and prescriber and pharmacy service system configurable for the specific needs of MLTC that feeds directly into our IT and TruCare Cloud systems. As a result, pharmacy-related information exchange with Nebraska Total Care and our provider networks are always simple, ensuring quick resolution of POS benefit configuration and provider credentialing issues, allowing members to obtain their needed medications timely.

Nebraska Total Care is always eager to help the Ponca Tribe pharmacies resolve point of sale issues preventing tribal clams from processing appropriately. When it was discovered an incorrect enrollment status code on the state Provider File for a Ponca Tribe pharmacy was causing claims to reject, the Nebraska Total Care Pharmacy team contacted the MLTC Provider Relations Program Manager and Maximus, MLTC's provider enrollment vendor, to facilitate resolution. In addition, to prevent member disruption or pharmacy burden of processing claims at a later date, Nebraska Total Care implemented point of sale edits to allow this pharmaciy's claims to continue to process without issue until the state Provider File was updated. Nebraska Total Care Pharmacy team provides exceptional support to the Ponca Tribe pharmacies."

– Dennis Schufeldt, Pharm D, Chief Pharmacist, Ponca Tribe of Nebraska

---

Extensive Reporting Using Integrated Claims Data. The CVS claims processing suite of systems offers a comprehensive set of automated reports that provide key financial and utilization statistics essential to analyzing the pharmacy benefits program. Example reports include:

- Drug Usage
- Management Activity
- Member Utilization
- Pharmacy Providers

Unlike many pharmacy benefit managers, CVS uses a hierarchy to set up eligibility, enabling reporting at many levels—including member, account, and group. CVS's comprehensive reporting supports a consultative approach to pharmacy benefit management and empowers the State to make important plan benefit and cost decisions based on claims data.

108. Describe how the MLTC PDL will be integrated into the Bidder's pharmacy claims system.
Page Limit: 2

Nebraska Total Care has over five years' experience implementing and maintaining the State's Preferred Drug List (PDL). In addition to our five years in Nebraska, Centene offers 38 years' experience in completing successful PDL implementations in new and highly penetrated markets with minimal disruption to participants. Nebraska Total Care has experience operating in Nebraska since 2017, adhering to the State PDL and ensuring the State's PDL is integrated within the claims processing system of our Prescription Benefits Manager (PBM) within MLTC required timelines.

Nebraska Total Care's pharmacy claims adjudication operator, CVS, has comprehensive experience implementing state-specific Medicaid Preferred Drug Lists (PDLs) in 18 states. As we do today, we will continue to meet the requirements in Section V.E.12.j of the Scope of Work (SOW) regarding introducing and maintaining the State-specific Preferred Drug List. CVS will continue to update its pharmacy claims processing system to support MLTC's defined adjudication methods including utilization of the MLTC PDL, prior authorization (PA) guidelines, other utilization management controls such as quantity limits and age limitations, and value-added pharmacy benefits, subject to MLTC approval.

PDL Integration and Configuration

MLTC State Specific PDL. Per the requirements outlined in Section V.E.12.j of the SOW, Nebraska Total Care follows the Nebraska Medicaid PDL and its class criteria, with preferred drugs being adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. Nebraska Total Care covers medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act and provides coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit.

PDL changes are recommended by the Nebraska Pharmaceutical and Therapeutics Committee and approved by MLTC before implementation. Nebraska Total Care nominates a non-voting member to be approved by MLTC that is responsible for attending the biannual meetings during the term of this contract, as outlined in Section V.E.12.j.vi of the SOW.

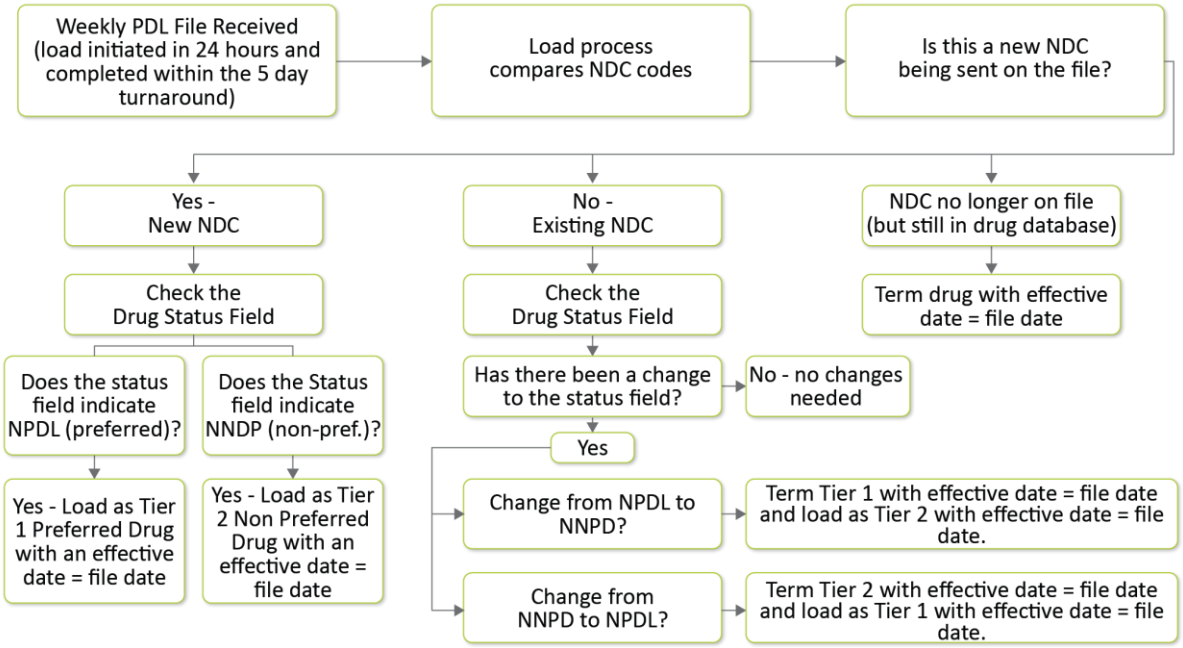
Configuring to Process the MLTC PDL File. CVS ensures the MLTC weekly National Drug Code (NDC) file from the MLTC PDL vendor is loaded within 24 hours of the file's receipt, and the data load to production is completed within five (5) days. Once the production load process is complete, the current preferred and non-preferred status of each NDC can be used for claims processing at the pharmacy point of service. CVS supports this timeframe today for Nebraska Total Care and supports bi-annual Pharmaceutical and Therapeutics Committee PDL file updates within 24 hours after the first day following the 30-day public notice. CVS has configured its data communications subsystem so that a scheduled process retrieves the MLTC's PDL file from their vendor and securely transmits that file to CVS' pharmacy claims processor. CVS' prescription drug claims processor configures and tests the claims system so that the PDL is translated for load into the claims system for production operations. The PDL file ensures that the pharmacy claims processing system will follow specific State PDL rules, including all related MLTC-required or approved criteria.

PDL Maintenance

Nebraska Total Care will continue to seamlessly integrate each weekly NDC PDL file sent from MLTC. CVS will continue to systematically receive the PDL from MLTC's vendor via our MIS per MLTC specifications each week. The PDL file is automatically formatted into the pharmacy claims processing system for an immediate load. The Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria is also loaded to the Nebraska Total Care Website and is accessible by providers and members.

The file the MLTC vendor provides has national drug codes (NDC) and delegates the preferred or non-preferred status of each NDC to maintain the PDL. CVS initiates the weekly PDL NDC file load within 24 hours and completes the update to its pharmacy claim system within five (5) business days of file receipt. At the direction of MLTC, CVS begins off-cycle and/or Pharmaceutical and Therapeutics Committee biannual changes to the PDL file within one (1) business day. Nebraska Total Care implements State Pharmacy and Therapeutics Committee-reviewed PDL changes, including clinical criteria changes, posted to the MLTC PDL website on the first day after the 30-calendar day public notice posting of such changes. Nebraska Total Care will continue to submit for review and written approval to MLTC, a minimum of 60 calendar days prior, all proposed value add formulary changes before implementing such changes. Nebraska Total Care will submit value add formulary prior authorization and step therapy policies and procedures and any associated criteria to MLTC for review and written approval, a minimum of 60 calendar days before implementation. Clinical criteria for prior authorization of drugs not on the PDL are also submitted to the MLTC for approval. Nebraska Total Care updates the formulary files at a minimum every week. We also perform off-cycle PDL updates within set timeframes when MLTC requires, offering additional operational flexibility. **Figure 108** provides a brief overview of the PDL load logic.

Figure 108 PDL File Load Logic



Nebraska Utilization Management Update (UM). Along with the PDL NDC file, the Nebraska Weekly UM Update File is provided by MLTC and systematically received from MLTC's vendor weekly. While the PDL file identifies Preferred versus Non-Preferred status, the UM file provides information regarding which drugs are subject to clinical or utilization edits as defined by MLTC. (Section V.E.12.j.i of the SOW). Nebraska Total Care processes the weekly UM file concurrently with the PDL NDC file within the MLTC required timeframes. NDC-specific UM edits are in place at the point of sale and include minimum/maximum age limitations, maximum dose, maximum quantity, or other edits, as defined by the state.

Member Experience

Point of Sale Experience

The Integration of the PDL into the Pharmacy Claims System enables a Point of Sale Experience that occurs ***within seconds***.

MLTC's PDL is loaded in our PBM's pharmacy claims system. At the point of sale, the member presents their identification card and prescription to the pharmacist. Claims for participating pharmacies are processed at the point of sale and transmitted online to CVS. More than 500 system-performed edits are executed, including formulary status, member, prescriber, and pharmacy eligibility, drug coverage, and concurrent drug utilization review (DUR). As appropriate, Smart Prior Authorizations, or Automated Prior Authorizations, which integrate state PDL clinical criteria requirements at the point of sale, are implemented. Pricing is applied and responses are immediately transmitted, advising the pharmacy of claim status (pay or deny), payable amount, member amount due, and applicable DUR messages. The entire process occurs within seconds.

In addition, members may submit paper claims for drugs purchased at the pharmacy that was not submitted at the point of sale. For example, if a member forgot their ID card and paid for their prescription out of pocket, they can get reimbursed by submitting a paper claim. Instructions on how to submit the paper claim are posted on our Nebraska Total Care website. Members may also call Nebraska Total Care and speak with a representative for help submitting paper claims.

Over-the-Counter Medications. Nebraska Total Care provides coverage for over-the-counter (OTC) medications listed in the Nebraska Medicaid Preferred Drug List. Nebraska Total Care maintains a current rebateable value add OTC drug list and will submit the list for review and approval by MLTC 120 days before the contract start date.

Rebates

CVS sends processed drug claims data to our Centelligence data warehouse, and Nebraska Total Care provides pharmacy claims information to MLTC so the State may perform PDL drug rebate activities. We will not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. Even if Nebraska Total Care or CVS has an existing rebate agreement with a manufacturer, all Medicaid outpatient PDL drug claims and provider-administered drugs will be rebateable exclusively to Nebraska Medicaid.

109. Describe the Bidder's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the Bidder proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor.
Page Limit: 5 (Per Addendum 3, Q&A #25 attachments are not included in the page limit)

Proven Encounter Processing Experience

Nebraska Total Care continues to exceed the Encounter Data Quality Performance Program (QPP) acceptance requirements as defined by MLTC and will continue to meet or exceed the requirements as described in contract Section S.10 Encounter Data and Attachment 6. Since 2018, Nebraska Total Care encounter acceptance rates for physical health, behavioral health, and pharmacy encounters combined, annually exceed the QPP measures for full payment above the 98% threshold as noted in **Table 109 Encounters Acceptance Rates**. The submitted encounters acceptance rate exceeds the 95% requirement and is in alignment with MLTC specifications. We are prepared to process dental encounters within the timeframe of July 1, 2023, the new contract implementation date with our affiliate Envolve Dental. Our CFO or designee attests to the truthfulness, accuracy, and completeness of all encounter data we submit to MLTC as defined in the contract requirements. Our encounters process is supported by software that ensures accuracy and timeliness from claim to encounter and includes processes that monitor encounter data that ensure completeness and accuracy. Our Centelligence reporting and analytics platform and Enterprise Data Warehouse (EDW) retain key information for managing the encounter data process. Our processes include monitoring and correcting claims and encounter data and validation by providers and Subcontractors for non-submission.

Table 109 Encounters Acceptance Rates

Encounters Acceptance Rates		
Year	**QPP Target %**	**QPP Acceptance %**
2018	98%	99.07%
2019	98%	99.40%
2020	98%	99.19%
2021	98%	99.14%
2022*	98%	99.39%
*Through April 2022		

Partnership Approach to Encounter Quality. We attribute our success in encounter data production to our end-to-end view of operations, from provider claim submission to encounter data preparation. We recognize that to support complete, accurate, and timely encounter submission in compliance with requirements 42 CFR § 438.242, 42 CFR § 438.818, 42 CFR § 438.604, and 42 CFR § 438.606, we must ensure accurate claims submission to minimize downstream errors and collect service information from providers in standardized formats. Our front-end controls help ensure complete, accurate, and timely encounter submission to support back-end encounter data preparation. Our approach includes:

- ***Enterprise Support Teams.*** Centene's Encounter Business Operations (EBO) and Encounter IT Teams provide day-to-day support. EBO is staffed with a dedicated Encounter Specialist to support Nebraska Total Care operations, leveraging the EBO's expertise, best practices, and lessons learned from affiliate health plans.
- ***Local Expertise.*** Our local Nebraska Total Care Claims Analysts have an in-depth understanding of MLTC-specific claims processing rules and provide critical feedback to claim configuration and encounter reporting processes. The Claims Team works with our Provider Relations (PR) Representatives to support provider education to resolve issues related to provider claim submissions.
- ***A Coordinated Team Approach.*** The EBO coordinates regular encounter meetings which include our Claims Analysts, dedicated Encounters IT staff members, and functional areas related to encounter submissions to ensure encounter performance requirements are consistently met. Agenda items include encounter status, including pass rates, paid claims to encounters reconciliation, as well as outstanding and upcoming business concerns; any underlying claims issues; and (3) Subcontractor encounter reporting status.

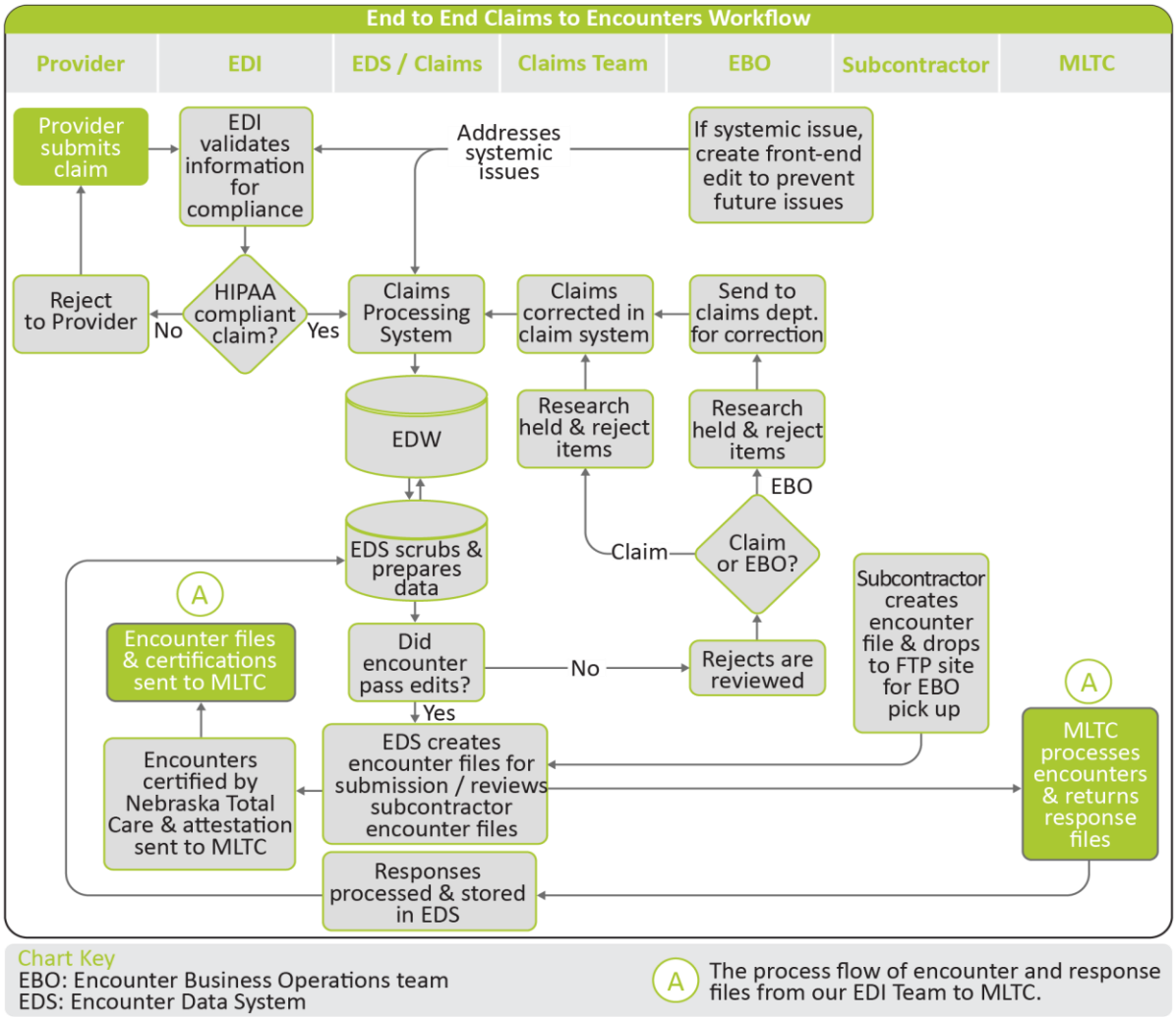
Technology Driven Processes to Ensure Encounter Data Accuracy and Timeliness

Proven Medicaid Encounter Data Software. We use an industry-leading Encounter Data System (EDS), an encounter workflow system specifically designed for managed care encounter processing. Our EDS is fully integrated with our enterprise Management Information System (MIS) and meets MLTC requirements. Refer to **Figure 109** End to End Claims to Encounter Workflow for a summary of our process for claims submission to encounter reporting.

From Claim to Encounter. From the collection of service information from providers in standardized formats and provider claim submission to encounter data preparation, we deliver complete, accurate, and timely encounter data in compliance with contract requirements and MLTC. We comply with industry-accepted clean claim standards, including capitated claims, by requiring the submission of complete and accurate data to support proper claims adjudication. Upon claim receipt, our compliance software validates data against ASC X12 HIPAA Version 5010 syntax, tests for conditional rules requiring secondary fields for data structure, tests for conditional rules requiring secondary fields, and ensures all data is following MLTC Companion Guides as we process the claim. We process claims through our middleware to map, translate, and validate the data to ensure that common edits are consistently applied, and all critical claim data elements are present in

sufficient detail to support comprehensive financial reporting and utilization analysis. If any transaction is rejected, we notify the Electronic Data Interchange (EDI) trading partner, submitting provider, or Subcontractor and convey the reason it did not pass validation processing. Prompt notification to providers and Subcontractors enables correction and resubmission of the claim so we can process and submit the encounter to MLTC promptly.

Figure 109 End-to-End Claims to Encounters Workflow



Equipped to Capture Encounter Claim Detail. Our MIS is configurable to meet all program requirements as defined by MLTC. We configure our systems and processes to accommodate any changes made by MLTC. For every clean claim, our encounter data displays the same line-item detail as received on the claim, regardless of claim type, and disposition (either paid or denied). We include fee-for-service (FFS) equivalent detail including, procedures, diagnoses, Diagnosis Related Group (DRG) as appropriate, National Drug Code (NDC), interest paid or recovered, zero paid claim lines, cost settlements, sub-capitated services, third party liability denials, and claim line adjustments. Encounter details include all services, the rendering provider's identification numbers, billed amounts, and paid amount information. An indication of whether the claim is original, adjusted, voided, denied, a replacement, or from a capitated service is included. Encounter data does not include claims rejected for HIPAA or EDI errors. The claims data received is reviewed for completeness and appropriateness during our EDI, pre-adjudication, and adjudication validation steps. This includes checks for data formatting, as well as member validation.

Aggregating Encounter Data within our EDW. Our Claims Processing System retains snapshots of all transactions, for example, paid, denied, suspended, appealed, changes, adjustments, and voids, and includes date span logic, historical claims tracking, operator ID stamping, and other audit parameters for operational monitoring and retrospective reviews. Our EDW retains all data elements billed by the provider and the claims detail history necessary for creating encounters in compliance with MLTC. See **Figure 109** End to End Claims to Encounter Workflow. Our EDW supports access to all data required to manage the encounter process, including encounter data reporting and capabilities to identify encounter

trends, monitor acceptance rates, and produce operational analytics.

Encounter Data Extraction and Preparation. We create encounter files per contract schedule requirements. Manual (ad hoc) requests are used for file creation outside the normally scheduled processes. Our EDS systematically extracts claims data from our EDW based on the claim paid to date to minimize bottlenecks and the need for manual intervention and ensure we meet reporting timeliness requirements. The EDS configuration of MLTC-specific business rules allows us to scrub the data before encountering data submission, to check data elements, and that the format is following MLTC requirements. EDS then produces Professional and Institutional Encounter files for MLTC in HIPAA compliant 837P (Professional) and 837I (Institutional) formats and National Council for Prescription Drug Program (NCPDP) formats for pharmacy encounters.

Encounter Submission via SFTP and Response. To confirm the successful transmission of file exchanges between Nebraska Total Care and MLTC, we monitor EDI acknowledgments issued by our state partners upon each weekly submission for encounter data including pharmacy. All files, including our Subcontractor encounter files (Pharmacy, Vision, Dental, and NEMT), are checked for HIPAA compliance before MLTC submission.

Encounter Error Correction and Resubmissions. Our EDS processes encounter response files, updates the encounter status, and identifies encounters for reprocessing for timely error resolution. The system's ability to receive and process encounter response file reports from MLTC facilitates encounter reconciliation workflows and prioritizes encounter correction activities. Encounter errors received in the response file and those encounters that failed scrub edits are sent to the appropriate team including, Claims, Provider Relations, EBO, etc., for root cause analysis and resolution. If an encounter file with an error needs reprocessing, we make corrections at the source in our Claims Processing System and resubmit through EDS. If an identified systematic error requires a system configuration change, we submit a configuration change request to correct program logic issues at the source. Once corrected, we resubmit encounter batches to MLTC or its agent in the next encounter cycle. These change management best practices ensure prompt implementation of any new edits or changes MLTC intends to implement regarding member encounter data. If MLTC rejects a file of encounter claims, we resubmit the rejected files with the required data elements in the correct format within 30 calendar days from the date we received the rejected file. Per the contract, we will address ninety percent (90%) of reported errors within thirty (30) calendar days and ninety-nine percent (99%) of reported errors within sixty (60) calendar days. If MLTC discovers errors or conflicts with a previously adjudicated encounter claim, we adjust the claim and resubmit the encounter as either a replacement or voided encounter within 30 calendar days of notification by MLTC. Encounter submission errors processed by our subcontracted vendors are corrected by the vendor in collaboration with EBO. Once corrected, those encounters are resubmitted in the next encounter cycle. Weekly encounter data from the EDW is combined with corrected encounters that need to be resubmitted. Batch files containing fatal errors preventing the processing of the file or exceeding the threshold record levels are corrected and resubmitted within one business day of receipt. Nebraska Total Care supports MLTC rebate dispute resolution promptly by assigning a single point of contact to research any encounters that are denied on submission or identified as a dispute by the manufacturer. Within thirty (30) calendar days, Nebraska Total Care will explain disputes at the encounter level, to MLTC. If claim information is in error, the encounter will be voided in five (5) business days of the determination.

Continuous Improvement. For continuous improvement, Nebraska Total Care Claims Analysts review and analyze each encounter rejection; work with IT teams and the EBO to correct any application defects, and work with the State to provide a solution to possible issues on their end. Centelligence offers encounters quality and monitoring dashboards which allow us to view the encounter process at the aggregate level, trended over time, to spot performance anomalies for operational improvement. For example, these dashboards will enable us to continually monitor MLTC encounter edits and rules (known as scrubs) that we have configured in EDS and identify trends. We regularly examine the highest encounter scrub reasons reported in EDS. Wherever possible, we use that information to move encounter edits that frequently occur on the back end (in EDS) – to the front end (EDI, Claims Processing System). This enforces those edits at the point of claim submission and rejects or denies inaccurate claims submissions as early as possible.

Subcontractor Monitoring. Our validation and oversight processes ensure quality Subcontractor encounter submissions to reduce errors, improve accuracy, and ensure timeliness. All Subcontractors who receive and process claim submissions from providers on behalf of Nebraska Total Care are contractually obligated to submit their encounter data to us for validation against MLTC-specific processing rules to determine the overall accuracy and ensure data can be submitted in HIPAA-compliant formats. We monitor Subcontractor performance metrics, including timely delivery of encounter files, appropriate coding and inclusion of data elements, and adherence to formats set forth by MLTC. Along with detailed biweekly attestation reports from the Subcontractors highlighting encounter submissions from the prior weeks, the EBO tracks and loads encounter response file summaries into EDS to validate the figures produced by each Subcontractor. If a

Subcontractor falls outside monthly performance guidelines, they are subject to liquidated damages and/or a Corrective Action Plan (CAP), as appropriate. Our Compliance Department monitors Subcontractor encounter submissions via quarterly Vendor Oversight Committee reviews with each Subcontractor. We understand the importance of visibility and ownership of Subcontractor encounter data and its performance and continue to refine existing logic to enhance EDS capabilities to capture and reconcile all encounter submissions.

Systems and Controls for Data Quality and Timeliness. Nebraska Total Care's success is predicated on the emphasis we put on front-end controls that assure data quality in our encounters. We leverage effective controls strategically positioned throughout the encounter data production lifecycle.

HIPAA Compliance. We systematically apply HIPAA compliance checks, validate the provider NPI, submitter, member, and provider information on all electronic inbound claims through our integrated MIS. Paper claims once converted into data, are processed through the same data validation routines and edits as electronically submitted claims. This process verifies all data follows HIPAA, Federal mandates, and MLTC payment rules. We deny provider claims due to a lack of sufficient or accurate data required for proper adjudication.

Configuring EDS for MLTC Compliance. EDS's table-driven configuration utility allows us to implement MLTC-specific business rules to scrub encounter data before submission to MLTC. The EBO uses EDS to identify encounters that fail our pre-submission scrubs before transmission so the issue can be corrected. Nebraska Total Care configures scrubs to prevent processing issues on MLTC's end by ensuring adherence to contract requirements, HIPAA compliance, data completion and accuracy, national industry standards and code sets, NPI edits, etc. If an encounter record does not pass an EDS scrub the system holds the encounter for review and correction. Wherever possible, encounter scrubs that occur frequently on the back end through EDS – are also added to the front end of our MIS, to enforce those edits at the point of claim receipt and reject or deny inaccurate claims submissions as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. If errors are identified, we work closely with providers to correct any issues and/or reprocess the claims for a valid encounter submission.

Systematic Methods to Ensure Timeliness. Nebraska Total Care validates that encounter submission files are successfully delivered to MLTC through EDI Functional Acknowledgements and the 277 Claims Acknowledgement transaction. We automate scheduled processing runs out of EDW on daily, weekly, or monthly cycles through our job scheduling software. Our workload automation software then executes scheduled file exchanges (transmission and receipt) with MLTC's agent, using any secure data transmission protocol, for example, SFTP, needed by MLTC.

Verifying Throughput. Using Centelligence, our EDI Operations Department can monitor the day-to-day throughput of inbound EDI claims from providers to ensure a smooth and timely flow of claim data, and alert Nebraska Total Care if high volume providers have lower than usual submission volumes for follow-up by our Provider Relations staff.

Proactive Approach for Subcontractor Non-submission

Nebraska Total Care's approach with our Subcontractors involves early communication of a deficiency related to reporting requirements, performance, or other contract or service issues. Our pre-delegation and annual re-assessment process consistently review and enforces the policies and procedures specific to Subcontractor delegated activities, including encounter submissions. All contracts with our Subcontractors include provisions to ensure the successful fulfillment of all Nebraska Total Care contractual obligations to MLTC. Our Subcontractor agreements outline our ability to enforce performance requirements and we include provisions requiring our Subcontractors to self-disclose if they are aware of any areas where they are not meeting requirements. We require monthly and quarterly reports from our Subcontractors, in addition to the bi-weekly reviews and attestations, demonstrating compliance with required performance metrics. Our pre-delegation and annual re-assessment process for Subcontractors consistently reviews and enforces policies and procedures specific to the delegated activities. Per contractual agreements with our Subcontractors, a QI Plan or CAP and financial sanctions may be applied if service level agreements related to encounter submissions to us are not met by our Subcontractors. Through this approach and regular status calls and meetings of our Vendor Oversight Committee, we can identify concerns at an early stage and immediately communicate our expectations for how to correct concerns within a 30-day timeframe. If we do not see a deficiency correction within that 30-day timeframe, we implement a CAP.

Monitoring Data Completeness and Non-Submissions

Monthly Claims to Encounter Reconciliation Review for Accuracy and Completeness. To ensure complete submission of monthly encounter data, Nebraska Total Care compares financial data from paid claims with corresponding encounter submissions to ensure encounter data is a complete representation of the services provided, matching paid dollars by the date of the service month. Using this process, we can account for every paid claim and verify that finalized claims have been

processed as encounters, including all payment adjustments. We leverage operational feedback to inform, adjust, and continuously improve each step in the Encounter process.

Weekly Acceptance and Reject Review. Upon receipt of the Subcontractor encounter submission files by the EBO team, the encounter file is processed through our compliance checking software to ensure that the encounter file has been produced per the State companion guide. We perform a weekly analysis to understand the acceptance rates received on the encounter submissions that week. This allows us to support our Subcontractors by identifying trends that require attention before they compromise the integrity of encounter timeliness, accuracy, and completeness. If the weekly acceptance rate is at risk at any time, our encounter resources (Nebraska Total Care, EBO, Claims, and IT Teams) work together to quickly identify and resolve the issue with our Subcontractors to meet or exceed MLTC's acceptance rates. If MLTC returns records to us for research and resolution, we act quickly to research and resolve encounter data issues.

Bi-Weekly Vendor Inventory Report. We require our Subcontractors to reconcile encounter submission files with separate paid claim reports to ensure all encounters are submitted. All Subcontractors are required to submit this Encounter Inventory Report on a bi-weekly basis. This enables us to proactively monitor the Subcontractor's encounter inventory and identify potential issues that risk our encounter data quality. When an issue is identified, the EBO meets with Nebraska Total Care and the Subcontractor to address and resolve the issue immediately. All teams meet regularly until the issue is addressed and any necessary process refinements are implemented. If control totals do not match between the paid claims report and encounter files, we perform root cause analysis with the Subcontractor and implement a solution before submission to MLTC. If necessary, we ensure that the Subcontractor develops a CAP.

Management of Non-submission of Claim and Encounter Data. Nebraska Total Care validates and assesses the non-submission of claims and encounters by providers and Subcontractors and implements corrective actions if needed. We utilize several strategies designed to mitigate against non-submission of claims from providers including support for electronic submissions, reporting, dedicated staff support, and provider training. Per our standard provider contracts, we require the submission of complete, timely, accurate claims (or provider-submitted encounters for capitated services) per Nebraska regulations. Our Provider Relations (PR) staff use a monthly claims submission report identifying providers by claim count and dollars billed, as well as top denial and adjustment reasons. This report allows our PR staff to proactively identify and outreach to providers requiring assistance.

Strategies to mitigate against non-submission

- Support electronic submissions
- Reporting
- Dedicated staff support
- Provider Training

Electronic Data Interchange (EDI) Claim Submitters. Centelligence produces daily reports on submissions from providers that enable Nebraska Total Care PR staff to monitor and identify providers who systemically submit incorrect information (impacting encounter data quality), allowing PR staff to assist via targeted training. PR staff also monitor high-volume EDI submitters in case support is needed, for example, atypical error rates, or drops in normal submission volumes, as well as high volume paper claim submitters to educate and support conversion to electronic submission.

Paper Claim Submitters. Our PR staff promotes the benefits of facilitated claim submission via our online Direct Data Entry offering, available through our web-based secure Provider Portal. We help providers see how online submission leads to quicker payment and allows them to manage their Accounts Receivables more accurately, simultaneously leading to higher quality claim submissions, and ultimately quality encounter data to MLTC.

Training and Supporting Providers Including Facilitating Clean Data Submissions. Nebraska Total Care uses a coordinated blend of targeted communications, training, and support strategies to help ensure that our providers realize the importance of submitting accurate, timely, and complete claim data, including the need to submit claims for all services rendered, whether Nebraska Total Care pays for those services on a fee-for-service (FFS) basis or a capitated schedule. This training and support also include encounter claims from capitated providers for capitated services, so we may in turn submit timely, accurate, and complete encounter data to MLTC. Our PR department offers providers face-to-face claims training at both regional and provider onsite venues, our EDI Help Desk assists providers with a toll-free number, and providers can turn to our website for scheduled and on-demand webinars and other online assistance. Through our secure Provider Portal, we offer access to the Clear Claim Connect tool, where providers can check our adjudication logic before claims submission. Providers also have access to our online Ramp Manager EDI system, which allows providers to onboard through interactive EDI testing and certification for direct EDI HIPAA file submissions to us with additional support from the EDI Help Desk, our PR staff, and Provider Service Representatives.

110. Describe the Bidder's proposed processes for coordination of benefits for dually eligible members.
Page Limit: 2

Experience Coordinating Benefits with Medicare Payers and Providers

Nebraska Total Care has administered coordination of benefits (COB) for dually eligible members with Medicare and Medicaid since its implementation in 2017. Nebraska Total Care currently offers a Highly Integrated Dual Eligible (HIDE) Special Needs Plan (SNP) in 37 counties in Nebraska with planned expansion to additional Nebraska counties in 2023 and is prepared to have a statewide HIDE SNP in place no later than January 1, 2024, in alignment with the contract requirement. We currently process claims for nearly 800 HIDE SNP members as described in **Figure 110**. We will continue to leverage our technology and established processes to handle Medicare cross-over claims, coordinate benefits, and administer Medicaid as the payer of last resort in compliance with Section V.S.15,16, and 17 of the Scope of Work, while coordinating care for our dual-eligible Heritage Health members.

Figure 110 HIDE SNP and Duals Crossover

Adjudication of Medicare Crossover Claims. Nebraska Total Care configures and uses our Claims Processing System, an integrated component of our Management Information System (MIS), to meet all MLTC requirements. We adhere to state provider bulletins and health plan advisories related to COB and Third Party Liability (TPL) processing, including but not limited to, MLTC guidance on lesser logic when Medicare is the primary payer. Nebraska Total Care has an existing COB Agreement for data feeds that support Medicare cross-over claims adjudication for secondary claims to Medicaid. When we receive a HIPAA 837 claim file from the Benefits Coordination and Recovery Center (BCRC), the Claims Processing System, integrated with our eligibility and enrollment Unified Member View (UMV), identifies the member with Medicare as the primary payer, validates COB identification information on the claim, and adjudicates the claim for remaining Medicaid benefits. Each claim is adjudicated using COB segment information in the 837 EDI claims file (which contains adjudication results as processed by Medicare) for secondary payment information. We process payment for all Medicare providers who see our dual-eligible members, including out-of-network providers enrolled with Nebraska Medicaid.

COB is an Opportunity to Coordinate Care. When we coordinate benefits, we also conduct Care Coordination with other payers, when necessary, especially among vulnerable populations and those with special health care needs, as allowed under HIPAA privacy rules. The Nebraska Total Care, Care Manager serves as the dually eligible member's regular point of contact and is actively involved in coordinating the member's full range of benefit delivery, regardless of which program pays for the service. For example, if there is a rejection for pharmacy claims that prevents payment due to dual eligibility, the Nebraska Total Care Pharmacy Team verifies whether the member has active Part D coverage in their State eligibility file. If there is no Part D insurance information on file, we remove the other insurance from the member's profile to allow the claim to be paid correctly and the Nebraska Total Care Pharmacy Team follows up with the eligibility team to prevent future point of sale rejections. For HIDE SNP members who have our Medicare and Medicaid products, our Claims Processing System shares that information across our systems for proper approvals and to decrease the provider's administrative burden.

COB Agreements (COBA). Nebraska Total Care has executed a COBA with the CMS BCRC and participates in the automated cross-over process for dually eligible individuals enrolled in Heritage Health. Our enterprise MIS currently supports the COBA-based claims cross-over process for Nebraska Total Care and several of our affiliates. We support the COBA Eligibility Record Layout format as provided by CMS. If a provider submits claims for a Nebraska Total Care dual eligible member to Medicare or a COBA participating Medicare Advantage plan for claims processing, Nebraska Total Care coordinates with the BCRC for Medicaid as the payer of last resort so that the provider need file their claim only once.

COB and Dual Reporting. To ensure proper coordination of benefits, we utilize a weekly HIDE SNP pharmacy claim report from Centelligence, our reporting and analytics platform, to help minimize inappropriate Medicaid coverage of Part D eligible drugs. For example, if a member recently became dual eligible, Nebraska Total Care reviews the claims allowed to process under a prior authorization (PA) and determines if continued payment under Medicaid is appropriate. If continued coverage is not appropriate, the PA is terminated to prevent any subsequent claims from paying. The PA termination date is automatically the day before the member became Part D eligible. In addition to reviewing for inappropriate coverage for HIDE SNP members, the Medicaid pharmacy claims report tracks HIDE SNP utilization, trends, spending, performance, and other metrics to ensure correct duals and HIDE SNP payment.

Unified Member View (UMV) - TPL Follows the Member

UMV functionality stores and maintains a member's eligibility history, enrollment and eligibility spans, and TPL information. We maintain up-to-date TPL information that follows the member supporting efficient COB, coordination of care, cost avoidance, and overall member management.

Identifying Members with Medicare as the Primary Payer. Upon receipt of the 834 eligibility file, TPL is automatically loaded to UMV, a component of our MIS, and shared via eligibility feeds to our claims-paying affiliated subcontractors for the administration of pharmacy, dental, NEMT, and vision benefits**.** For pharmacy, claims processing and reimbursement configuration are based on other coverage codes (OCC) submitted by the pharmacy and TPL to ensure Medicaid is the payer of last resort and that there is no coverage of Part D copays. Our MIS systematically captures TPL and Other Insurer information from inbound claims, and our MIS is integrated with Health Management Systems, Inc. (HMS), so that we receive updated TPL and COB data on our members, including Medicare and Medicare Advantage coverage. HMS is a leading cost containment company specializing in the systematic collection of TPL/COB information using a nationwide database. Through Centelligence we report members with third-party coverage to MLTC monthly. We supply MLTC with TPL information weekly and cooperate in any way necessary with MLTC or its cost recovery vendor.

We Identify Members with Other Insurance. Through our vendor Cotiviti, we have a pre-pay review process for members with other primary insurance coverage not identified in our system. The process reviews claims as they are submitted. For members identified as having other primary coverage, the provider receives a notice on the Nebraska Total Care remittance indicating primary carrier EOB is needed. Our systems are updated with the identified other carrier information and require no administrative work from providers.

Key Partnerships to Identify COB/TPL. We take a proactive, comprehensive approach to identifying, collecting, and reporting TPL coverage and cost avoidance. As mentioned above, we use HMS, an established leader in TPL identification and post-payment recovery in the public sector. Providers and our staff help to identify TPL for members, including those members dually eligible for Medicare and Medicaid. When we use COBA, the BCRC supplies us with Medicare enrollment information via cross-over claims.

Nebraska Total Care Staff Support. All our staff that interface with members are trained and provided the appropriate tools and resources to assist dual-eligible members with questions about their Medicaid and Medicare-covered benefits, appeals and grievance rights, and other issues unique to dual-eligible members. Staff is trained to assist dual eligible members across a continuum of member interactions, including welcome calls, outreach and education, health risk screenings, Care Management, and care transition.

Provider Support. Our provider agreements include contractual provisions requiring identification of any other coverage before submitting claims to us. Through regular provider orientations, ongoing training meetings, and our online provider handbook, we educate our providers on the importance of identifying TPL information (including Medicare) when the member receives services. We inform and educate providers about the importance and process for submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties and include payment information from a third party where member liability exists. We ask for this information in the TPL/COB payer segments of their HIPAA 837 EDI claim submissions, or third-party EOBs with their paper claims submissions.

Sharing, Exchanging and Reporting TPL through Centelligence. Nebraska Total Care recognizes that TPL information is a component of capitation rate development and other administrative activities. We maintain records regarding Medicare coverage, and other TPL information, as well as TPL and COB recoveries to MLTC in the timeframe and format determined by MLTC. Our ability to collect, manage, and report data through one uniform production and reporting system, Centelligence, our reporting, and analytics platform, allows us to offer an all-encompassing holistic view of the programs and benefits we administer.

RFP 112209 O3

B. Technical Approach

V.T Reporting and Deliverables

V.T Reporting and Deliverables

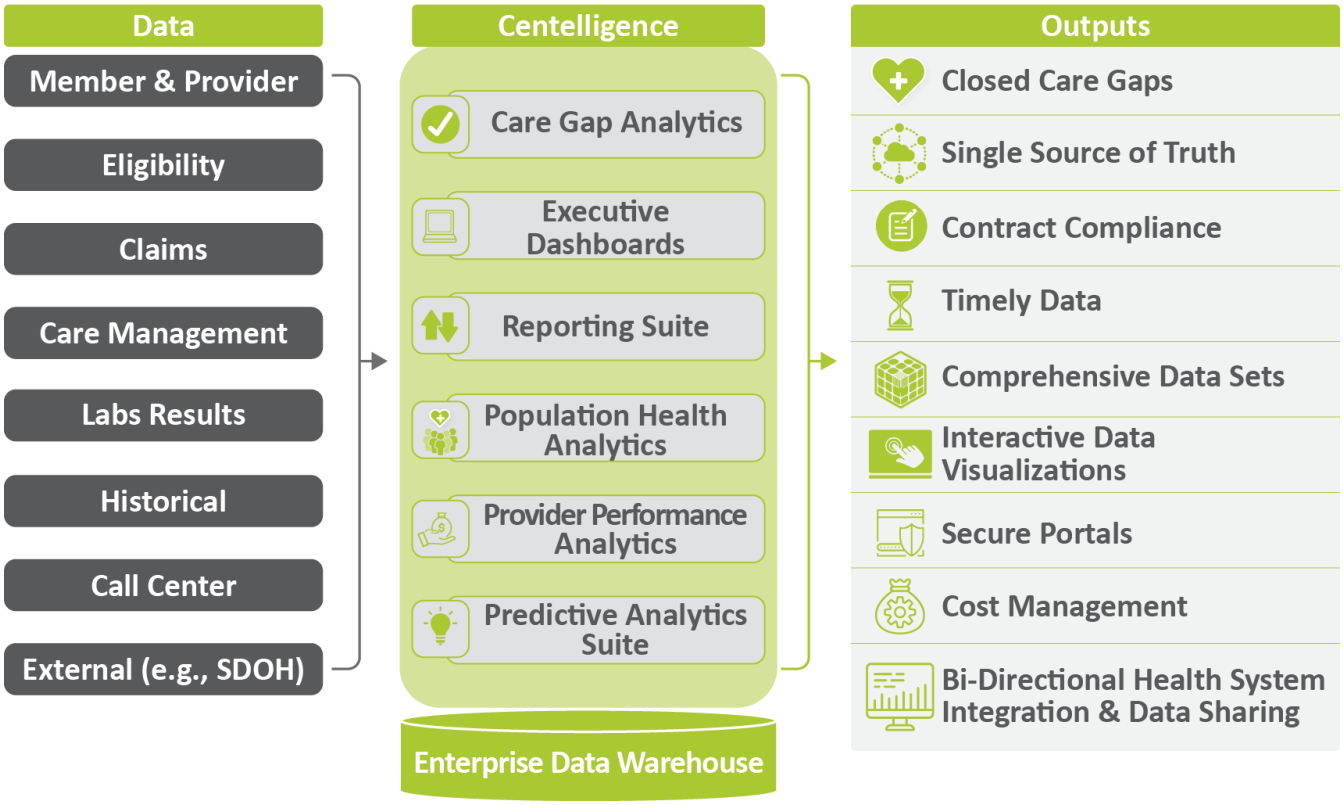
111. Provide an example of dashboards that the Bidder will use to track Bidder performance for Bidder leadership and the QAPI Committee.

Page Limit: Not applicable

Analytics and Reporting Platform

Nebraska Total Care uses an integrated and interoperable Management Information System (MIS) provided by our parent company, Centene Corporation. A key component of our MIS is the Centelligence reporting and analytics platform. Centelligence is our proprietary, comprehensive suite of integrated reporting and analytics decision tools. It provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill-down capabilities. As demonstrated in **Figure 111.A, Centelligence Reporting and Analytics Platform**, Centelligence pulls data from our Enterprise Data Warehouse (EDW) to aggregate information from our operational and clinical areas, including member, provider, eligibility, claims, care management, call center, and pharmacy data sets. It combines this with historical and external data, such as CyncHealth HIE data, to create meaningful, insightful dashboards and ad hoc reports.

Figure 111.A. Centelligence Reporting and Analytics Platform



We can report on all datasets in our platform, including those for Health Equity, Social Determinants of Health (SDOH), HEDIS, CMS Adult and Child Core Measure sets, EPSDT services, call center statistics, clinical operations performance, claims timeliness, Performance Improvement Project informatics, and other critical aspects of our operations. We can drill down and stratify all available demographics including geography, age, sex, race, ethnicity, and language.

Available Dashboards. Within the Executive Dashboard Hub, Nebraska Total Care's leadership team has access to a large variety of standard reports and dashboards which allow our leaders to monitor and track plan performance. Descriptions of these standard dashboards are included in **Table 111.A.** Our leadership teams review and monitor these reports to assess operational performance. On a monthly basis, action plans for measures that do not reach Key Performance Indicator (KPI) or contractual compliance targets are followed to ensure operational performance stabilization and target achievement.

Table 111.A. On Demand Leadership Dashboards

Dashboard Name	Description
Executive Portal	Enterprise profitability analytics tool that allows for drill-down on profit and loss by product, provider, region, etc. Brings together premiums, caps, claims expense, and other data at the per member per month (PMPM) level. **See example dashboard in Figure 111.J**.
Leading Indicators Executive Portal	Provides overall business insights to metrics and trends across the enterprise's domains and transforms dashboards into actionable interfaces. Combines four current leading indicator dashboards into a single view. Each dashboard is represented on a color-coded map comparing plan projections to forecasts. The dashboard is custom-tailored by executive leadership to display the most used KPIs across domains in one location. Navigation provides direct links to underlying dashboards and other applications. **See example dashboard in Figure 111.K.**
Business Operations Dashboard	Organizes and presents information for first-time claims for receipts, auto adjudication, per 1,000 claims paid and denied, pends, voids, rejects, encounters, and monthly interest. **See example dashboard in Figure 111.L.**
Clinical Initiatives Dashboard	A data visualization tool for executive and clinical leadership to easily assess and compare the performance of clinical interventions across health plans. Allows Nebraska Total Care to identify and seek best practices across the enterprise. **See example dashboard in Figure 111.M.**
Encounters Dashboard	Supplies data/reporting for Encounter Business Operations essential measures of accuracy, timeliness, and completeness. Helps leverage both State-assigned criteria along with internally defined measures to ensure encounters are in compliance. Contains tiered reporting to support both analysts and executive management. **See example dashboard in Figure 111.N.**
Provider Dashboard	Demonstrates the network status (i.e., par and non-par) of providers within our health plan by product. **See example dashboard in Figure 111.O.**
Enterprise HBR (Health Benefits Ratio)	Enterprise profitability analytics tool that allows for drill-down on profit and loss by plan, product, provider, region, etc. Brings together premiums, caps, claims expenses, and other data at the member/month level**. See example dashboard in Figure 111.R**.

Centelligence includes a suite of leading-edge predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications. It can identify and report significant health risks at the population, member, and provider levels. These care gaps and health risk alerts power our online care gaps, allowing members and providers to securely access actionable health information, via our secure Member and Provider Portals. By using Centelligence, we can create reports enabling us to identify care quality and provider training opportunities, and high-performing providers for primary care assignments. Descriptions of these standard dashboards are listed in **Table 111.B.**

Our leadership teams frequently review and monitor these quality dashboards and reports to assess operational performance. On a quarterly basis, the QAPI Committee and its subcommittees review data in these reports. We develop and follow action plans for measures that do not reach KPI or contract compliance targets to assure operational performance stabilization and target achievement. In addition to the standard reports listed, our plan has developed custom, monthly, ad hoc reports to compare specific HEDIS, CAHPS, and STARS measure performance on a real-time member and provider-level basis.

Table 111.B. QAPI Committee Dashboards

Dashboard Name	Description
Health Equity Dashboard	Our Health Equity Dashboard displays performance across HEDIS measures by race and ethnicity. The Dashboard's geomaps overlay SDOH census data to help target interventions that are impactful in promoting health equity and measuring outcomes of disparity-reduction initiatives. **For an example, see Figure 111.P**.
SDOH KPI Dashboard	Our Neighborhood, Economic, and Social Traits (NEST) predictive analytics tool identifies members and communities with SDOH needs and provides a single indicator, or "score," for a member's risk of adverse health outcomes. The NEST tool leverages over 200 sources of publicly available data, such as county health rankings, hospital, and county community health needs assessments, school performance reports, USDA Food Access Research Atlas, CDC Social Vulnerability Index, and the American Community Survey. The

Dashboard Name	Description
	NEST tool provides insight into the social, economic, and environmental conditions members and communities experience in the neighborhoods where they live – hot-spotting SDOH needs to target community initiatives. This insight is augmented by our SDOH KPI Dashboard, which includes detailed member-level data, such as claims and assessments, with drill-down capabilities allowing users to analyze member patterns and trends in social barriers to care. The dashboard shows SDOH screenings completed by month by the health plan and Z code claims submitted by providers. It further indicates members with SDOH needs by category (for example, food insecurity, housing, education). We built additional analytics capabilities to allow staff to drill down on SDOH information by population segments such as age, race/ethnicity, Value-Based Purchasing contract, and provider to identify trends around SDOH and to intervene with additional supports and programming. **For an example see Figure 111.Q.**
Health Benefits Ratio Dashboard (HBR)	Dashboard with drill down capability, used by Nebraska Total Care leadership team and QAPI Committee to understand its medical loss ratio for the plan over a period of time and the key factors contributing to that health benefits ratio (medical loss ratio). Underlying data is analyzed to determine if different approaches need to be taken to contain costs or drive more utilization of proactive health services. **For an example see Figure 111.R.**
Quality Dashboards	Overview of HEDIS measures with drill down capability, used by QAPI Committee to understand year-to-date performance on individual HEDIS measures as well as compare that performance to prior years, projected HEDIS percentiles and projected STARS performance levels. This data is used to adjust action plans to improve member health outcomes and increase Nebraska Total Care's HEDIS and STARS performance. **For an example see Figure 111.S.**
Grievance and Appeals Dashboard	This report provides operational KPIs for the grievance and appeals area. The QAPI Committee monitors timeliness, average turn-around times, overturn percentages and volume of grievances and complaints to ensure Nebraska Total Care remains compliant with regulations and contractual obligations. This report is also used as a point of reference to gauge overall member and provider satisfaction as well as emerging grievance and appeals trends. **For an example see Figure 111.T.**
Credentialing Report	This report provides operational KPIs for the credentialing area. The QAPI Committee monitors timeliness, average turn-around times, volume of providers credentialed and sanction status to ensure Nebraska Total Care remains compliant with regulations and uses these statistics as a point of reference for member and provider satisfaction. **For an example see Figure 111.U.**
Care Management Dashboard	The Care Management Dashboard aims to provide a transparent overview of the Care Management status and performance metrics within our organization. The dashboard displays the compliance rate of the case management status, with the ability to drill down by plan, product, line of business, and region. It creates transparency around Care Management efficiency and productivity by providing detailed productivity metrics, trending over time, and benchmarking against internal and external standards.
Population Health Dashboard	The Population Health Dashboard provides up-to-date information related to the health status of members who are the most vulnerable, most impactable, and have the highest utilization and costs under our care. Drill-down capabilities provide an ability to analyze trends, socio-demographic differences, disparities, and neighborhood health statistics, allowing us to gain insight on how to effectively improve health outcomes.
CARE Satisfaction Dashboard	The CARE Satisfaction Dashboard allows for tracking call volume and member survey responses over time by health plan, product, call center location, and language. It allows our Nebraska plan to identify and seek best practices across the enterprise.
Authorization Dashboard	The Authorization Dashboard provides enterprise and plan-level insight into authorization staff productivity. The visuals and supporting reports provide one-stop transparency around received authorizations, including metrics like volume, status, and closeness to turn-around time.

Dashboard Name	Description
Medical Director Dashboard	The Medical Director Dashboard provides a transparent overview of Medical Director productivity and reviews quality outcomes within our health plan and our other affiliate health plans. The dashboard and associated detailed reports can be used for a variety of needs including staffing projections, productivity metrics, quality assurance, and many others.
Rx Leading Indicators	The Rx Leading Indicators tool organizes and presents KPIs for Rx daily and monthly trends. Metrics include actual scripts trended over 13 months, monthly generic versus brand script comparisons, and top 10 highest drug expenditures.
Specialty Drug Dashboard	The Specialty Drug Dashboard provides metrics from medical and pharmacy claims in a summarized view to measure specialty drug trends.
Neonate Leading Indicators Dashboard	This dashboard provides a daily projection of neonate metrics (admits, days, and average length of stay (ALOS)) based on authorizations. It includes a 13-month trend and a visual of the gestational age of the members compared to history.
Start Smart for Your Baby®-Predictive Analytic Tools	Care Management uses this suite of tools to prioritize outreach to pregnant members based upon claims, notice of pregnancy, and other claims data and information. Utilizing predictive analytics, these tools provide recommended, prioritized potential member needs and necessary care interventions. These tools summarize overall population data for C-section rates, notice of pregnancy timeliness, and other pregnancy-related statistics.

Future Enhanced Dashboard Reporting. Because we embrace data-driven solutions and continuous improvement, our organization has a pipeline of new and improved dashboard enhancements. Dashboards currently in development with scheduled release dates over the next 18 months include:

- ***Medicare Dual Special Needs Programs (D-SNP) Dashboard*** – The Medicare D-SNP Dashboard will provide automated KPI dashboards reflecting operational metrics that are unique to dual-eligible special needs plans (D-SNPs). These reports will draw on the experience of other Centene D-SNP plans and will adjust to our emerging experience in Nebraska. We will align the implementation of these dashboard tools to the D-SNP Contract deadlines.
- ***Quality Analytics Dashboard*** – This suite of dashboards provides automatic reporting dashboards and data processes to ensure reliable, timely, transparent, and actionable insights into Quality Ratings (such as HEDIS, STARS, and CAHPS). These interactive dashboards allow users to drill down into supplemental data used to support HEDIS, Risk Adjustment, and Clinical Analytics. This dashboard automates and integrates the chart chase and retrieval process and data to better support Quality and Risk Adjustment through additional charts, more timely and accurate data, and less provider abrasion.
- ***Child Welfare Dashboard*** – Our Child Welfare Dashboard provides visibility into our membership by race/ethnicity, age, gender, and segments by population type within child welfare (Foster Care System). Users can gain a deeper understanding on access to services through various utilization metrics such as emergency department (ED), primary care, and inpatient admissions and readmissions. Users can explore major practice groups and episode treatment groups to uncover specific health needs in the population. New functionality in progress includes health equity analysis, SDOH, and Care Management/Care Coordination engagement. This insight allows us to identify areas of opportunity for focused interventions and over and underutilization trends.

Example Dashboards

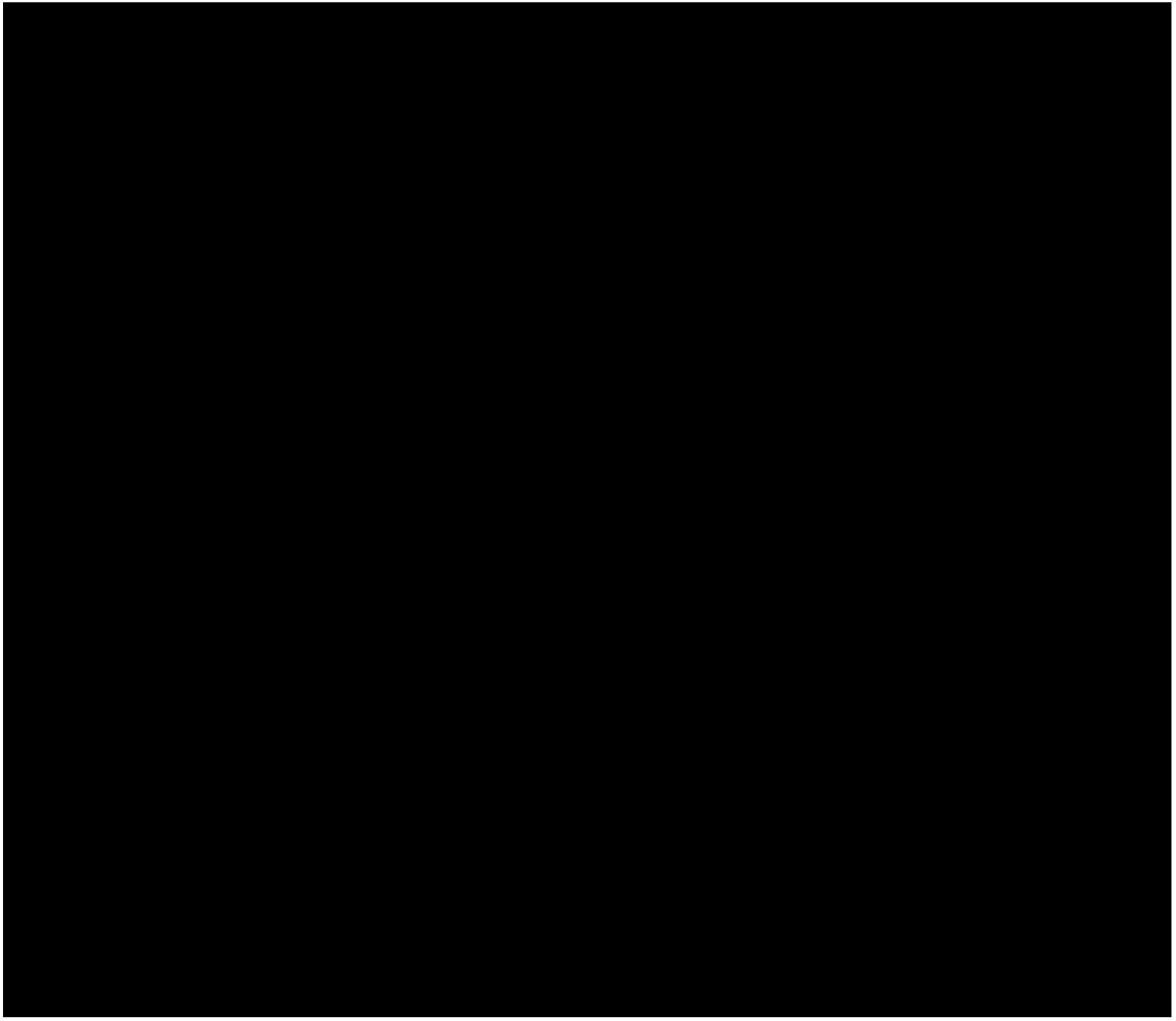
On the following pages, we provide a variety of examples of how our leadership teams and our QAPI Committee, and sub-committees use our Centelligence reporting and analytics platform to inform our decision-making. **Table 111.C** provides an overview of the Executive Data Hub dashboards used by Nebraska Total Care Leadership depicted in **Figures 111.B through 111.O**.

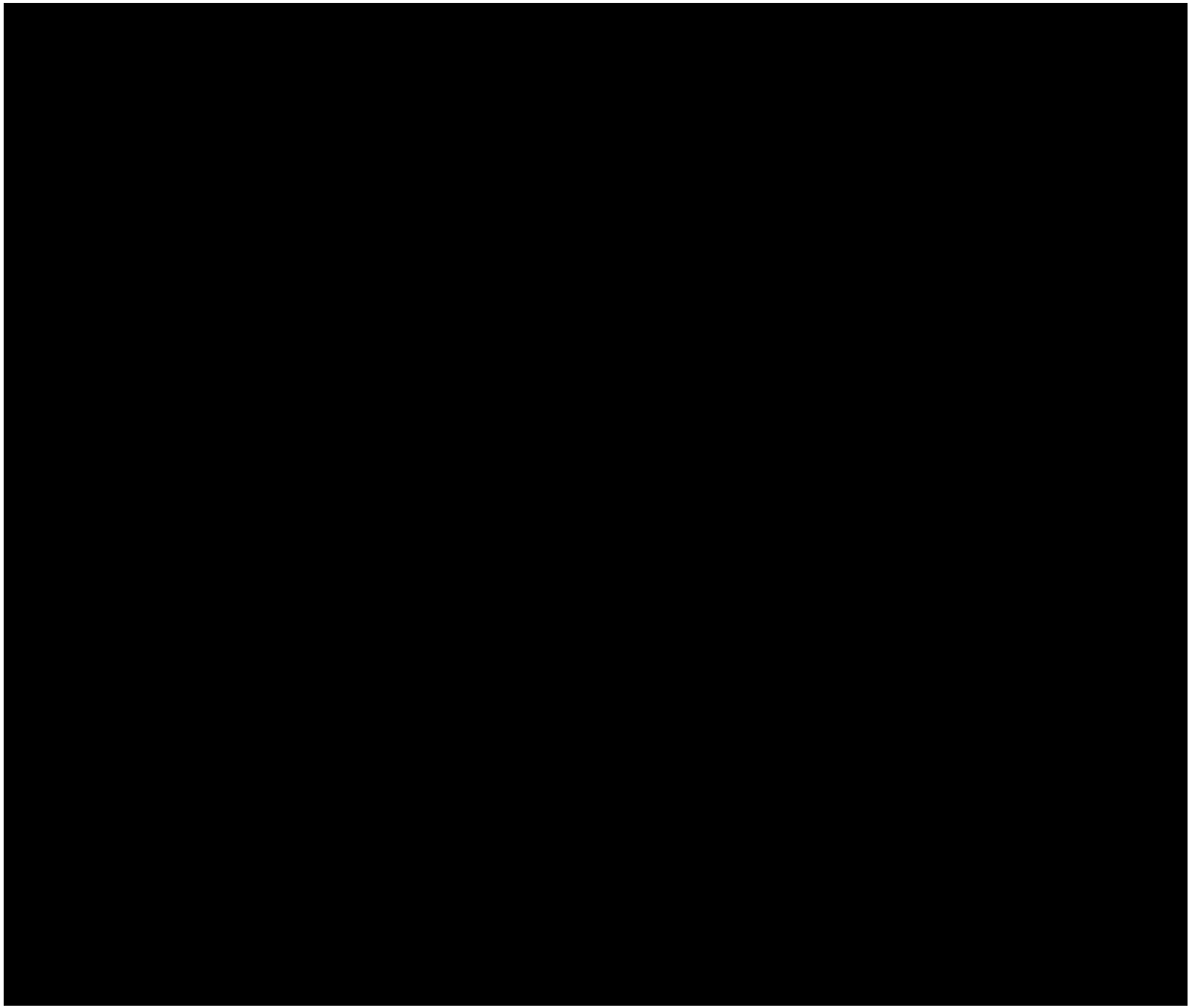
Table 111.C. Leadership Dashboard Overview

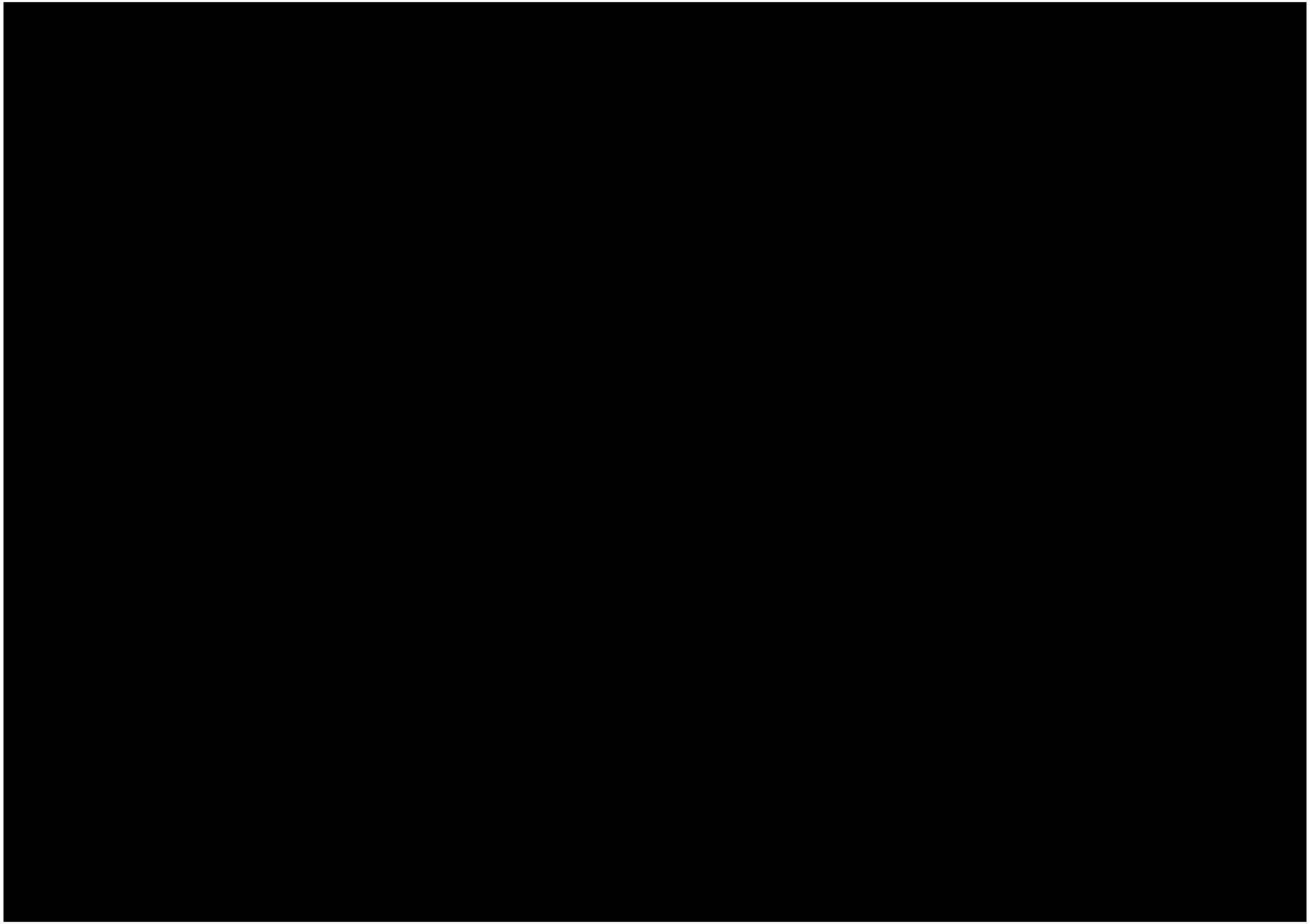
Figure Number	Dashboard Name	Description
111.B	Market Operations KPI Dashboard	Monthly Nebraska Total Care dashboard with KPIs for every functional area of operations, both clinical and non-clinical. Trends and insights are developed by providing a rolling 13-month view of each KPI. KPIs outside of target are highlighted in red and KPIs near upper and lower target limits are highlighted in yellow. On a

Figure Number	Dashboard Name	Description
		monthly basis, action plans for measures that do not reach targets are followed to assure operational performance stabilization and target achievement.
111.C	MCO State Dashboard	MLTC mandatory reporting dashboard for all MCOs. This dashboard is produced and submitted monthly to MLTC and contains many of the same measures included on the Market Operations KPI dashboard. On a monthly basis, action plans are developed for any measures that do not achieve KPI or contractual compliance targets and closely monitored to assure operational performance stabilization and target achievement.
111.D	Membership Dashboard	This dashboard provides insight into membership trends for Nebraska Total Care over a rolling 12-month period. Users may drill down by product, coverage, enrollment, and disenrollment trends to lend insights into member satisfaction and operational effectiveness.
111.E	Care Management Productivity and Efficiency Dashboard	These dashboards are used by Care Management leadership teams to understand the effectiveness and efficiency of departments, teams, and individual performers within Nebraska Total Care's Medical Management team. These reports help leaders assess the effectiveness of training, adoption of new workflows and practices, and gain insights into where teams or individuals may need additional training and assistance.
111.F	Subcontractor Dashboard – Pharmacy	Monthly pharmacy dashboard with operational KPIs utilized to ensure compliance with internal targets and contractual obligations. Data is provided over a rolling 12-month period allowing Nebraska Total Care to locate emerging trends and ensure appropriate oversight of responsibilities delegated to our pharmacy subcontractor.
111.G	Subcontractor Vendor Oversight Committee – Envolve Vision	This is an example of the dashboard provided by our vision Subcontractor and reviewed, on a quarterly basis, by a cross-functional team of Nebraska Total Care leadership in conjunction with the cross-functional leadership team of our vision subcontractor. During these meetings, emerging trends are discussed and action plans developed for any areas where KPI targets are not being met or are in jeopardy of not being met in the future. Actions plans are followed until measures are stabilized and targets achieved.
111.H	Example Dental Subcontractor Dashboard – Available 7/1/23	This is an example of the operational KPIs and contractual performance metrics that will be supplied to Nebraska Total Care each month post-go-live. Similar to other dashboards, action plans will be developed and followed for metrics that are trending negatively or not achieving targeted levels.
111.I	Non-Emergency Transportation (NEMT) Subcontractor Oversight Dashboard	Monthly operational metrics are reviewed by the Nebraska Total Care leadership team and subcontractor oversight committee to ensure the NEMT subcontractor remains in compliance with all contractual obligations.
111.J	Executive Portal Dashboard	Profitability analytics tool that allows for us to drill-down on profit and loss by product, provider, region, etc. Brings together premiums, caps, claims expense, and other data at the per member per month (PMPM) level.
111.K	Leading Indicators – Executive Portal	This dashboard is often the starting place for many leaders to gain an overall view of the plan's performance on KPIs. The dashboard may be custom-tailored by each user to display the most used KPIs across domains in one location. Navigation provides direct links to underlying dashboards and other applications.
111.L	Business Operations Dashboard	Organizes and presents information for first-time claims for receipts, auto adjudication, per 1,000 claims paid and denied, pends, voids, rejects, encounters, and monthly interest.
111.M	Clinical Initiatives Dashboard	A data visualization tool, for executive and clinical leadership, to easily assess and compare the performance of clinical interventions across health plans. Allows Nebraska Total Care to identify and seek best practices across the enterprise.
111.N	Encounters Dashboard	Encounters dashboards supply data/reporting for Encounter Business Operations essential measures of accuracy, timeliness, and completeness. It helps leverage both

Figure Number	Dashboard Name	Description
		State-assigned criteria along with internally defined measures to ensure encounters are in compliance. Contains tiered reporting to support both analysts and executive management.
111.O	Provider Dashboard	Demonstrates the network status (i.e., par and non-par) of providers within our health plan by product.







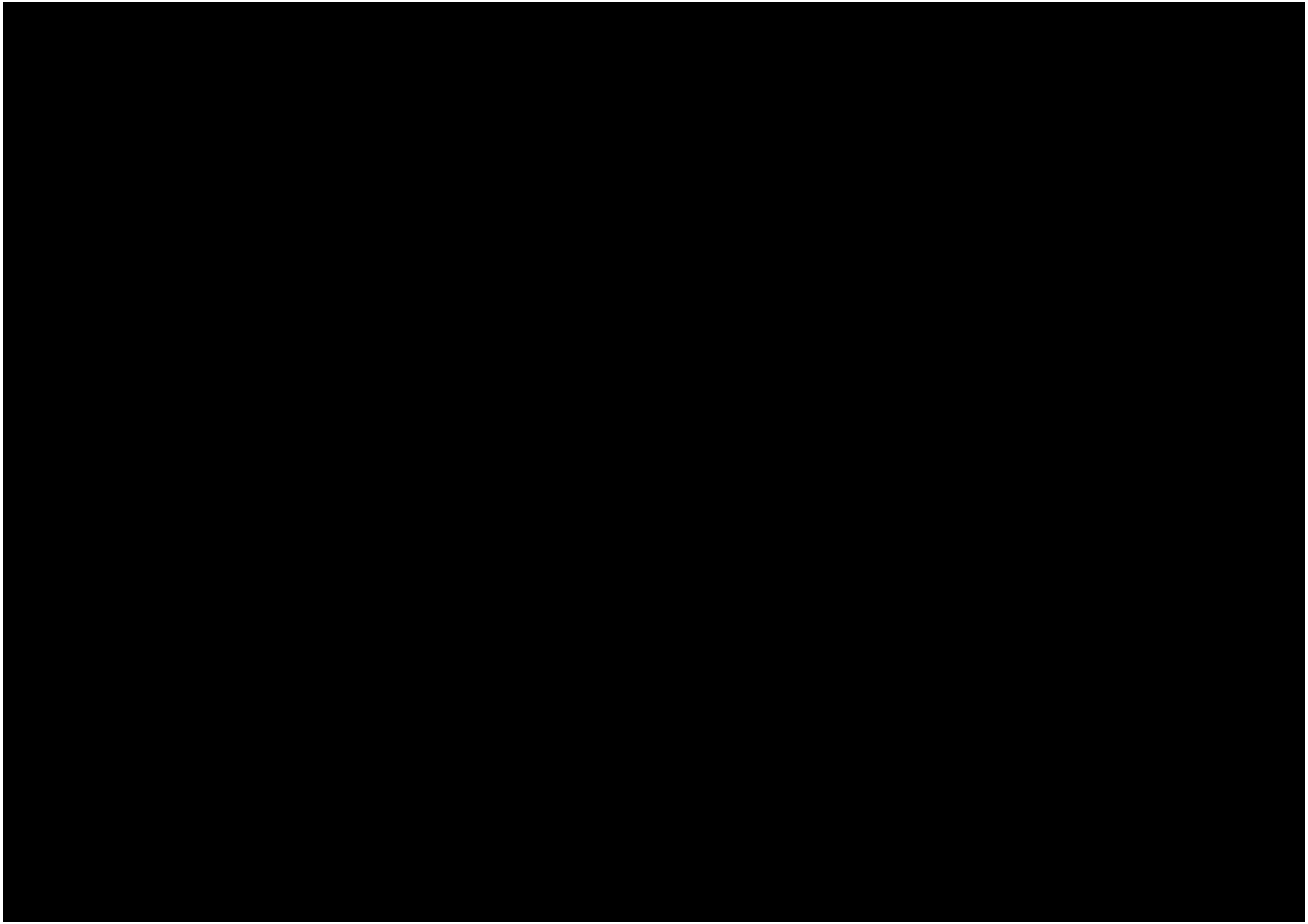
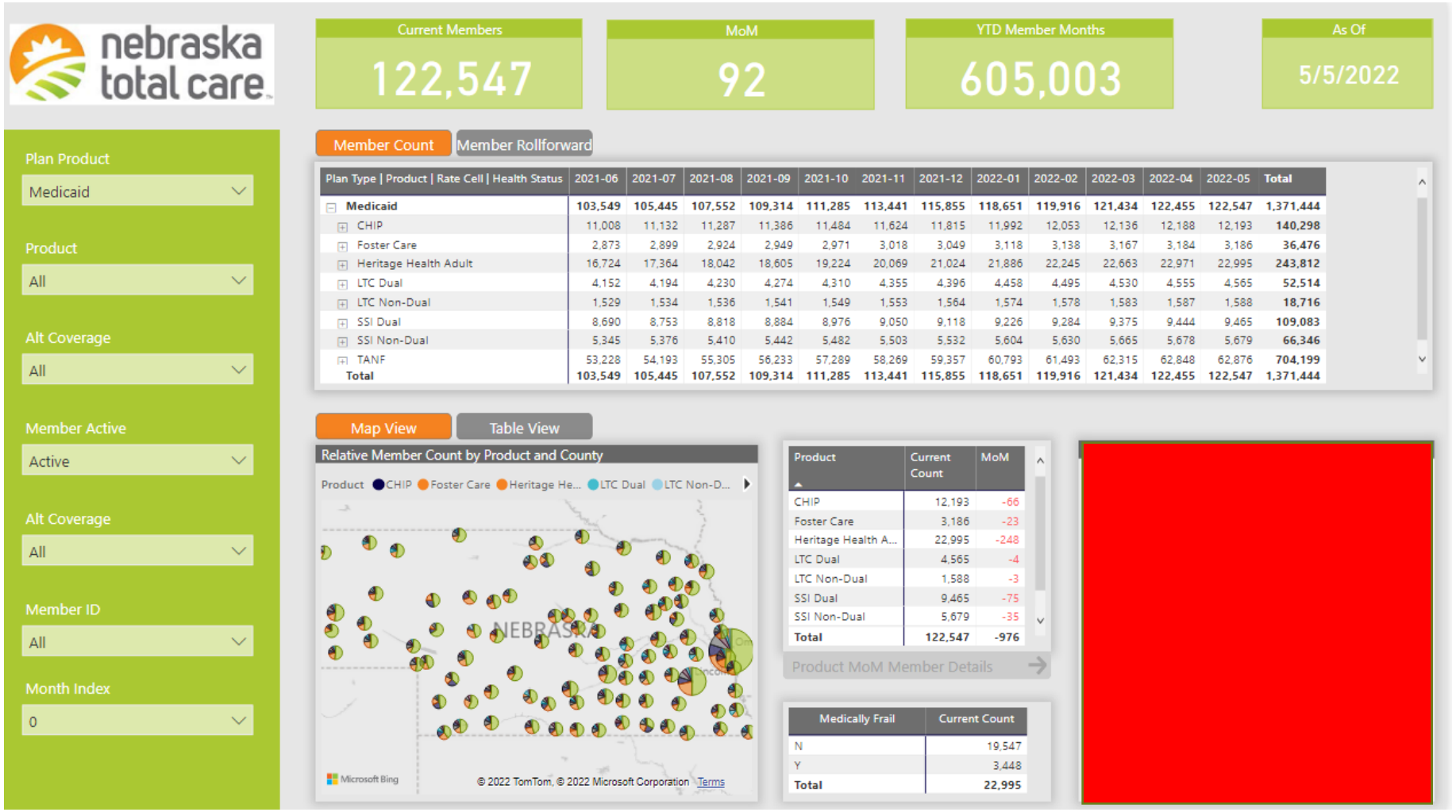


Figure 111.D. Membership Dashboards



Plan Type | Product | Rate Cell | Health Status	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	Total
Medicaid	**103,549**	**105,445**	**107,552**	**109,314**	**111,285**	**113,441**	**115,855**	**118,651**	**119,916**	**121,434**	**122,455**	**122,547**	**1,371,444**
CHIP	11,008	11,132	11,287	11,386	11,484	11,624	11,815	11,992	12,053	12,136	12,188	12,193	**140,298**
Foster Care	2,873	2,899	2,924	2,949	2,971	3,018	3,049	3,118	3,138	3,167	3,184	3,186	**36,476**
Heritage Health Adult	16,724	17,364	18,042	18,605	19,224	20,069	21,024	21,886	22,245	22,663	22,971	22,995	**243,812**
LTC Dual	4,152	4,194	4,230	4,274	4,310	4,355	4,396	4,458	4,495	4,530	4,555	4,565	**52,514**
LTC Non-Dual	1,529	1,534	1,536	1,541	1,549	1,553	1,564	1,574	1,578	1,583	1,587	1,588	**18,716**
SSI Dual	8,690	8,753	8,818	8,884	8,976	9,050	9,118	9,226	9,284	9,375	9,444	9,465	**109,083**
SSI Non-Dual	5,345	5,376	5,410	5,442	5,482	5,503	5,532	5,604	5,630	5,665	5,678	5,679	**66,346**
TANF	53,228	54,193	55,305	56,233	57,289	58,269	59,357	60,793	61,493	62,315	62,848	62,876	**704,199**
Total	**103,549**	**105,445**	**107,552**	**109,314**	**111,285**	**113,441**	**115,855**	**118,651**	**119,916**	**121,434**	**122,455**	**122,547**	**1,371,444**

Product	Current Count	MoM
CHIP	12,193	-66
Foster Care	3,186	-23
Heritage Health A...	22,995	-248
LTC Dual	4,565	-4
LTC Non-Dual	1,588	-3
SSI Dual	9,465	-75
SSI Non-Dual	5,679	-35
Total	**122,547**	**-976**

Medically Frail	Current Count
N	19,547
Y	3,448
Total	**22,995**

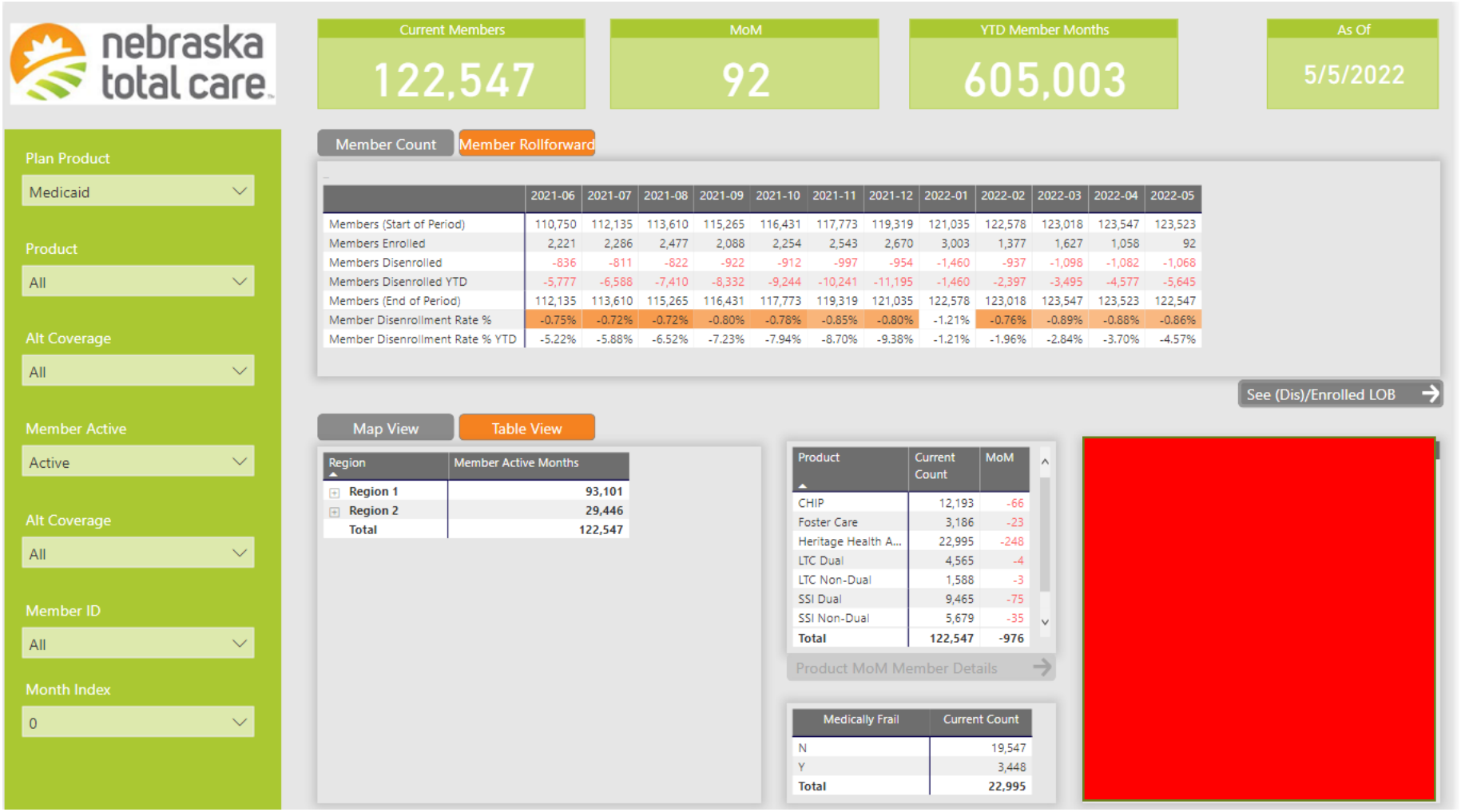
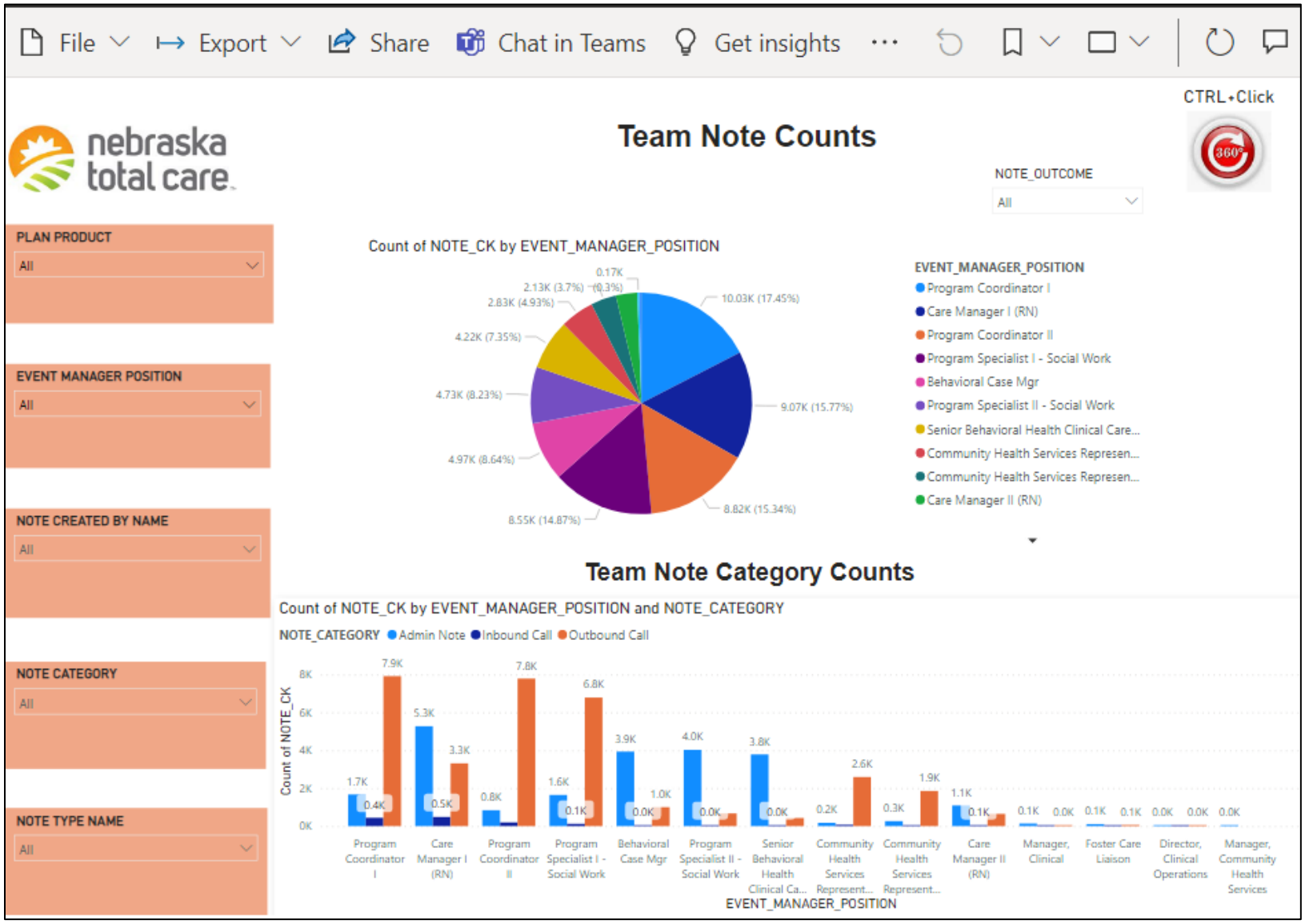
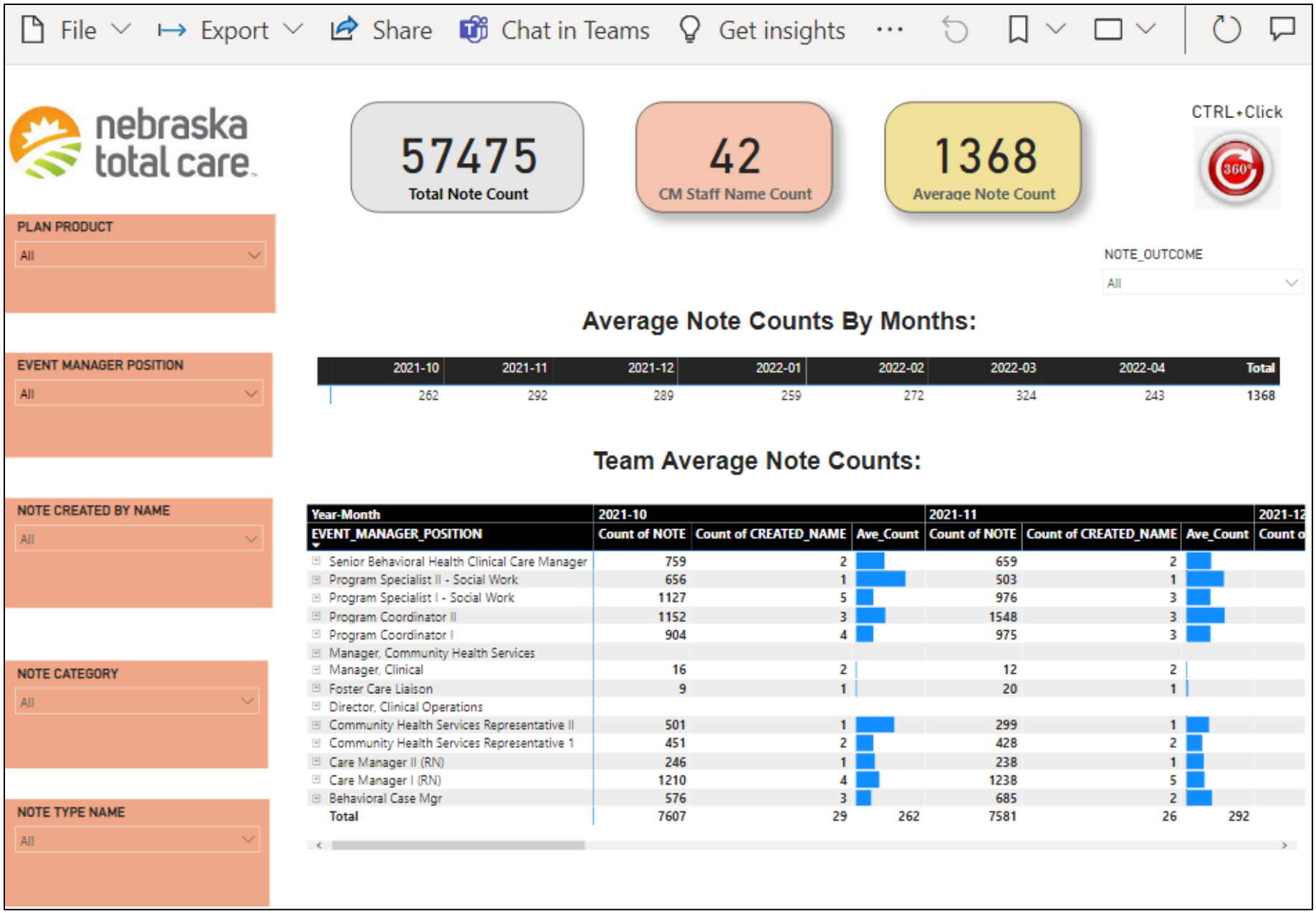
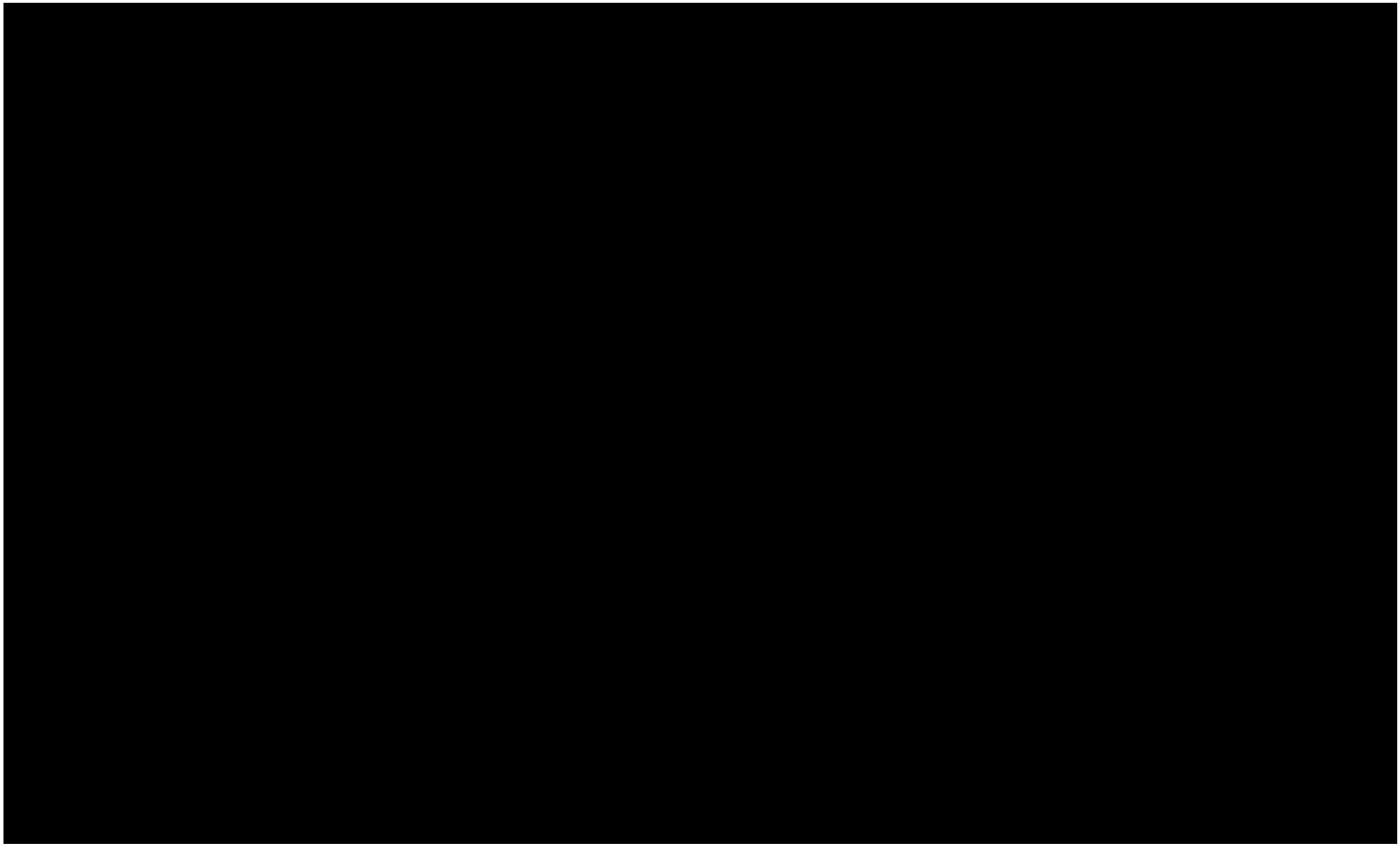

nebraska total care
Current Members
122,547
MoM
92
YTD Member Months
605,003
As Of
5/5/2022
Plan Product
Medicaid
Product
All
Alt Coverage
All
Member Active
Active
Alt Coverage
All
Member ID
All
Month Index
0
Member Count
Member Rollforward
2021-06 2021-07 2021-08 2021-09 2021-10 2021-11 2021-12 2022-01 2022-02 2022-03 2022-04 2022-05
Members (Start of Period) 110,750 112,135 113,610 115,265 116,431 117,773 119,319 121,035 122,578 123,018 123,547 123,523
Members Enrolled 2,221 2,286 2,477 2,088 2,254 2,543 2,670 3,003 1,377 1,627 1,058 92
Members Disenrolled -836 -811 -822 -922 -912 -997 -954 -1,460 -937 -1,098 -1,082 -1,068
Members Disenrolled YTD -5,777 -6,588 -7,410 -8,332 -9,244 -10,241 -11,195 -1,460 -2,397 -3,495 -4,577 -5,645
Members (End of Period) 112,135 113,610 115,265 116,431 117,773 119,319 121,035 122,578 123,018 123,547 123,523 122,547
Member Disenrollment Rate % -0.75% -0.72% -0.72% -0.80% -0.78% -0.85% -0.80% -1.21% -0.76% -0.89% -0.88% -0.86%
Member Disenrollment Rate % YTD -5.22% -5.88% -6.52% -7.23% -7.94% -8.70% -9.38% -1.21% -1.96% -2.84% -3.70% -4.57%
See (Dis)/Enrolled LOB
Map View
Table View
Region
Member Active Months
Region 1 93,101
Region 2 29,446
Total 122,547
Product
Current Count
MoM
CHIP 12,193 -66
Foster Care 3,186 -23
Heritage Health A... 22,995 -248
LTC Dual 4,565 -4
LTC Non-Dual 1,588 -3
SSI Dual 9,465 -75
SSI Non-Dual 5,679 -35
Total 122,547 -976
Product MoM Member Details
Medically Frail
Current Count
N 19,547
Y 3,448
Total 22,995

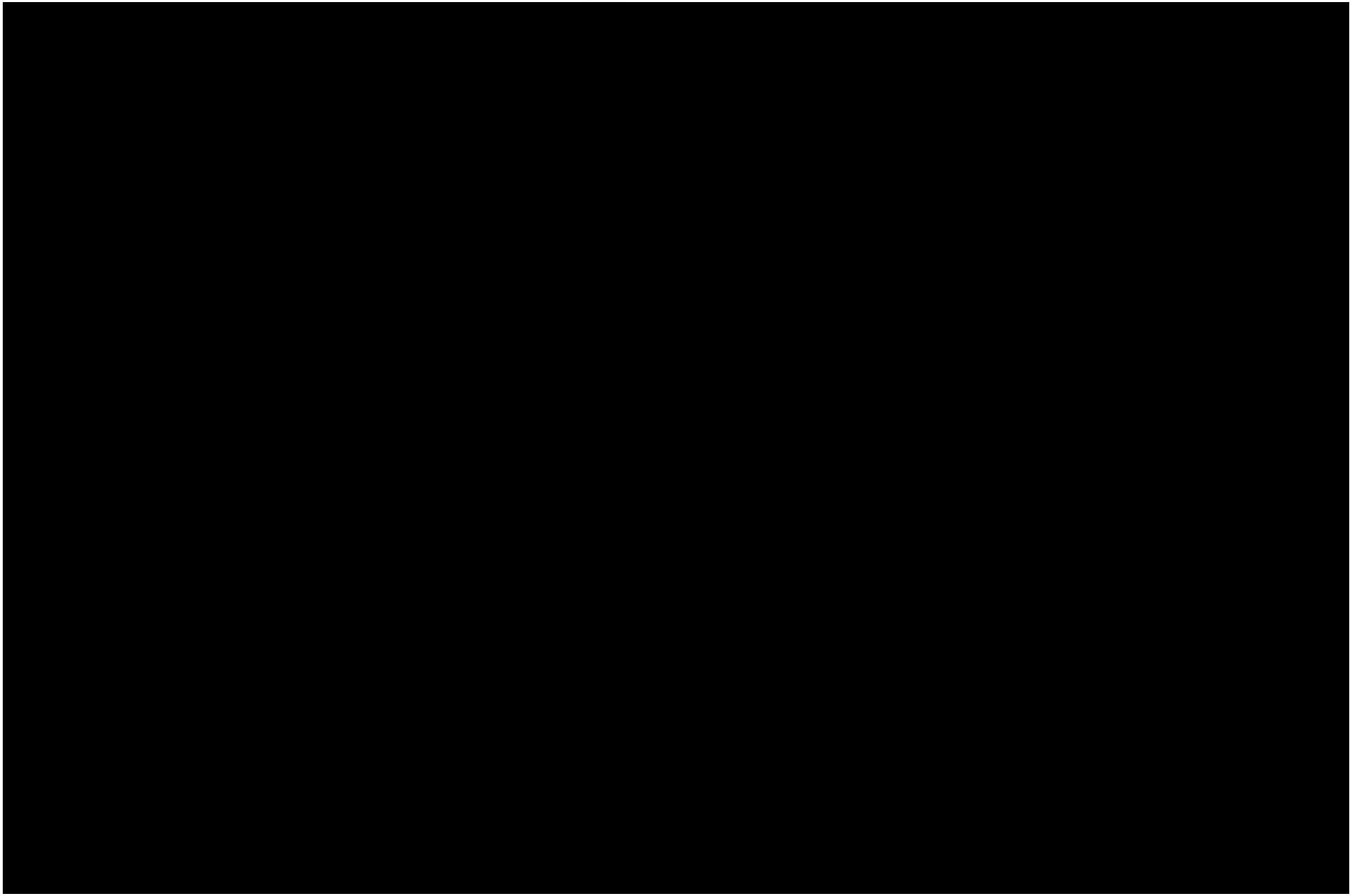
Figure 111.E. Example of Care Management Productivity and Efficiency Dashboards

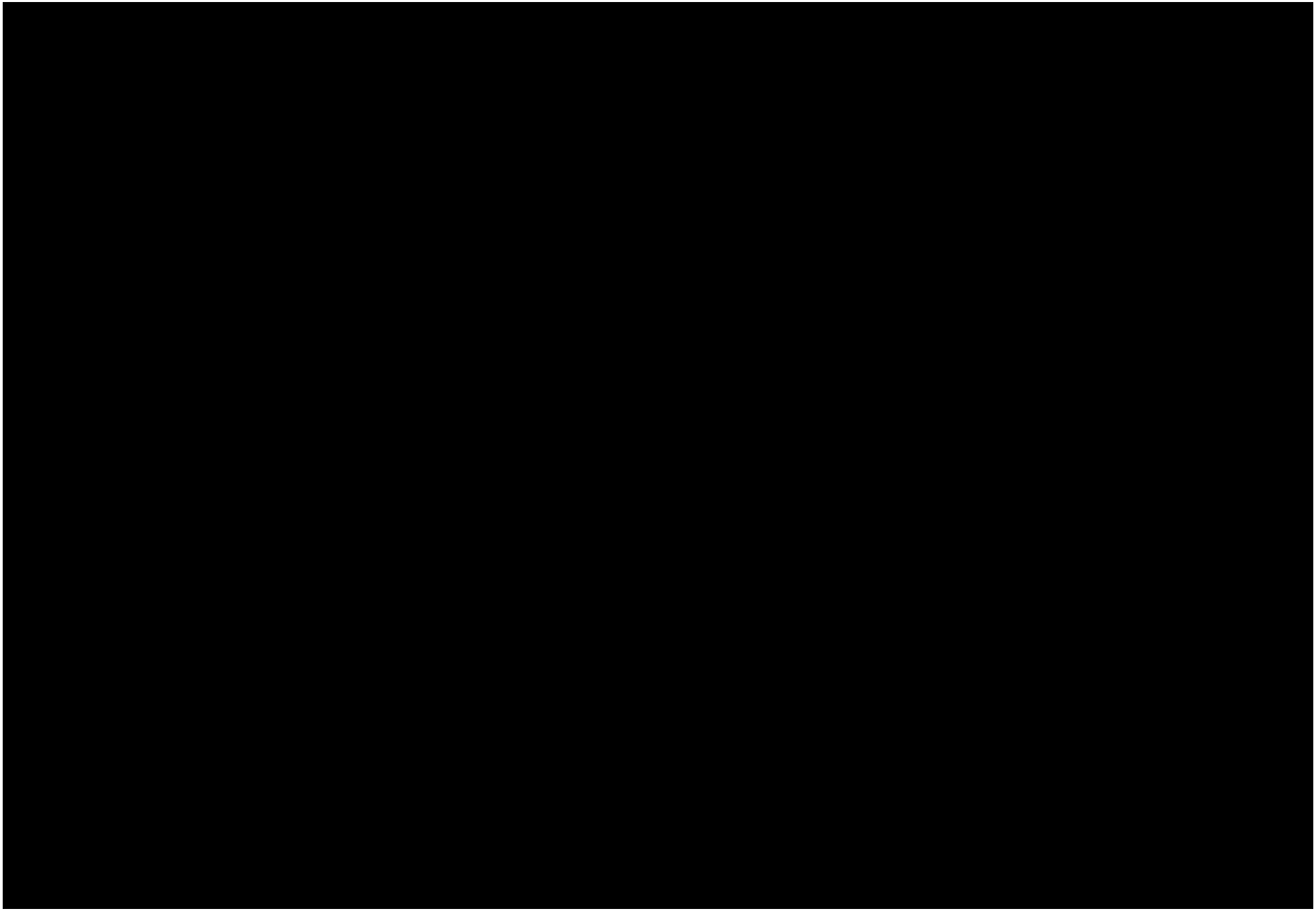




Year-Month	2021-10			2021-11			2021-12
EVENT_MANAGER_POSITION	Count of NOTE	Count of CREATED_NAME	Ave_Count	Count of NOTE	Count of CREATED_NAME	Ave_Count	Count o
Senior Behavioral Health Clinical Care Manager	759	2		659	2		
Program Specialist II - Social Work	656	1		503	1		
Program Specialist I - Social Work	1127	5		976	3		
Program Coordinator II	1152	3		1548	3		
Program Coordinator I	904	4		975	3		
Manager, Community Health Services							
Manager, Clinical	16	2		12	2		
Foster Care Liaison	9	1		20	1		
Director, Clinical Operations							
Community Health Services Representative II	501	1		299	1		
Community Health Services Representative 1	451	2		428	2		
Care Manager II (RN)	246	1		238	1		
Care Manager I (RN)	1210	4		1238	5		
Behavioral Case Mgr	576	3		685	2		
Total	7607	29	262	7581	26	292	







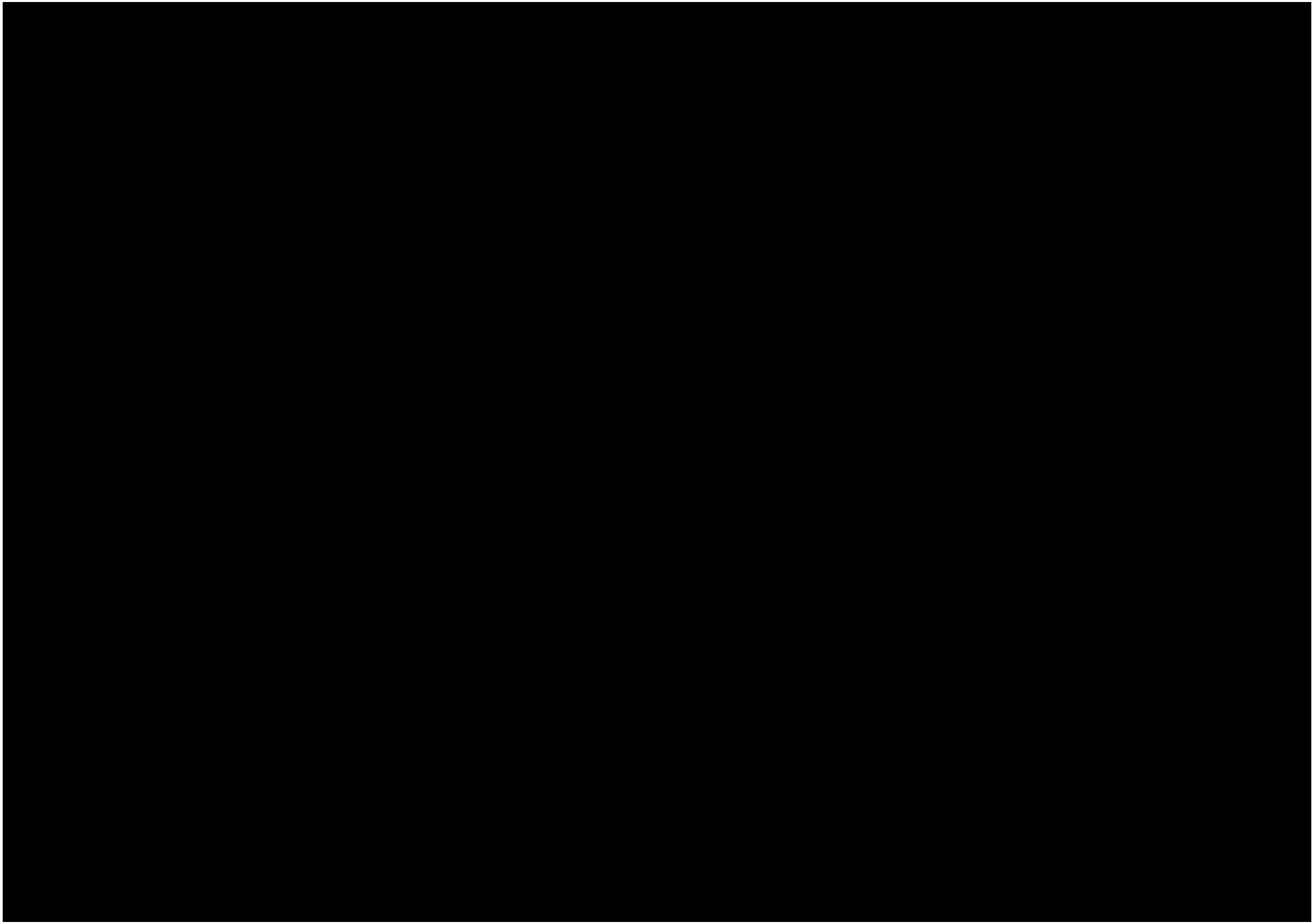


Figure 111.H. Example Dental Subcontractor Dashboard available by 7/1/23 Go Live

ID	Category	Metric Description	Type	Month
Field #	Eligibility	Metric		Mar-22
1.1	Eligibility	Number of member eligibility files loaded	#	
1.2	Eligibility	SLA value for timely load	#	
1.3	Eligibility	Number of eligibility files loaded timely	#	
1.4	Eligibility	Percentage of eligibility files loaded timely	%	
1.5	Eligibility	Number of active members at month end	#	
Field #	Reports	Metric		Mar-22
2.1	Reports	Number of individual reports sent	#	
2.2	Reports	Number of individual reports delivered timely	#	
2.3	Reports	Percentage of individual reports delivered timely	%	
2.4	Reports	Benchmark requirement for timely report delivery	%	
Field #	Encounters	Metric		Mar-22
3.1	Encounters	Reporting Year CY	abc	
3.2	Encounters	Percentage of Encounters Accepted for CY Paid Dates	%	
3.3	Encounters	Reporting Year PY	abc	
3.4	Encounters	Percentage of Encounters Accepted for PY Paid Dates	%	
Field #	Complaints	Metric		Mar-22
4.1	Complaints	Total number of complaints received	#	
4.2	Complaints	Total number of complaints resolved	#	
4.3	Complaints	Number of provider complaints received	#	
4.4	Complaints	Number of provider complaints resolved	#	
4.5	Complaints	Number of provider complaints resolved in 5 or less business days	#	
4.6	Complaints	Percentage provider complaints resolved in 5 or less business days	%	
4.7	Complaints	Number of provider complaints resolved in 6 or more business days	#	
4.8	Complaints	Percentage provider complaints resolved in 6 or more business days	%	
4.9	Complaints	Average number of business days for provider complaint resolution	#	
4.10	Complaints	Percentage of received provider complaints resolved within 30 calendar days	%	
4.11	Complaints	Number of provider complaints received per 1000 members	#	
4.12	Complaints	Number of member complaints received	#	
4.13	Complaints	Number of member complaints resolved	#	
4.14	Complaints	Number of member complaints resolved in 5 or less business days	#	
4.15	Complaints	Percentage member complaints resolved in 5 or less business days	%	
4.16	Complaints	Number of member complaints resolved in 6 or more business days	#	

ID	Category	Metric Description	Type	Month
4.17	Complaints	Percentage member complaints resolved in 6 or more business days	%	
4.18	Complaints	Average number of business days for member complaint resolution	#	
4.19	Complaints	Percentage of received member complaints resolved within 30 calendar days	%	
4.20	Complaints	Member Complaints per 1000 Members	#	
4.21	Complaints	Number of resolved complaints regarding Denial of requested services	#	
4.22	Complaints	Number of resolved complaints regarding Dissatisfied w/ Access/Availability of Services	#	
4.23	Complaints	Number of resolved complaints regarding Dissatisfied Provider-Services (General)	#	
4.24	Complaints	Number of resolved complaints regarding Eligibility Issues	#	
4.25	Complaints	Number of resolved complaints regarding Pricing/Billing dispute	#	
4.26	Complaints	Number of resolved complaints regarding Dissatisfied w/ Provider/Staff Attitude	#	
4.27	Complaints	Number of resolved complaints regarding Dissatisfied Member-Services (General)	#	
Field #	**Credentialing**	**Metric**		**Mar-22**
5.1	Credentialing	Total number of provider credentialings completed	#	
5.2	Credentialing	Number of initial provider credentialings completed	#	
5.3	Credentialing	Number of initial provider credentialings completed within 15 days	#	
5.4	Credentialing	Percentage of initial provider credentialings completed within 15 days	%	
5.5	Credentialing	Number of initial provider credentialings completed within 20 days	#	
5.6	Credentialing	Percentage of initial provider credentialings completed within 20 days	%	
5.7	Credentialing	Number of initial provider credentialings completed within 30 days	#	
5.8	Credentialing	Percentage of initial provider credentialings completed within 30 days	%	
5.9	Credentialing	Number of initial provider credentialings completed within 45 days	#	
5.10	Credentialing	Percentage of initial provider credentialings completed within 45 days	%	
5.11	Credentialing	Number of initial provider credentialings completed within 60 days	#	
5.12	Credentialing	Percentage of initial provider credentialings completed within 60 days	%	
5.13	Credentialing	Number of initial provider credentialings completed within 90 days	#	
5.14	Credentialing	Percentage of initial provider credentialings completed within 90 days	%	
5.15	Credentialing	Number of initial provider credentialings completed within 180 days	#	
5.16	Credentialing	Percentage of initial provider credentialings completed within 180 days	%	
5.17	Credentialing	Average TAT for initial credentialing	#	
5.18	Credentialing	Number of provider re-credentialings completed	#	
5.19	Credentialing	Number of provider re-credentialings completed within 36 months of initial credentialing date	#	
5.20	Credentialing	Percentage of provider re-credentialings completed within 36 months of initial credentialing date	%	

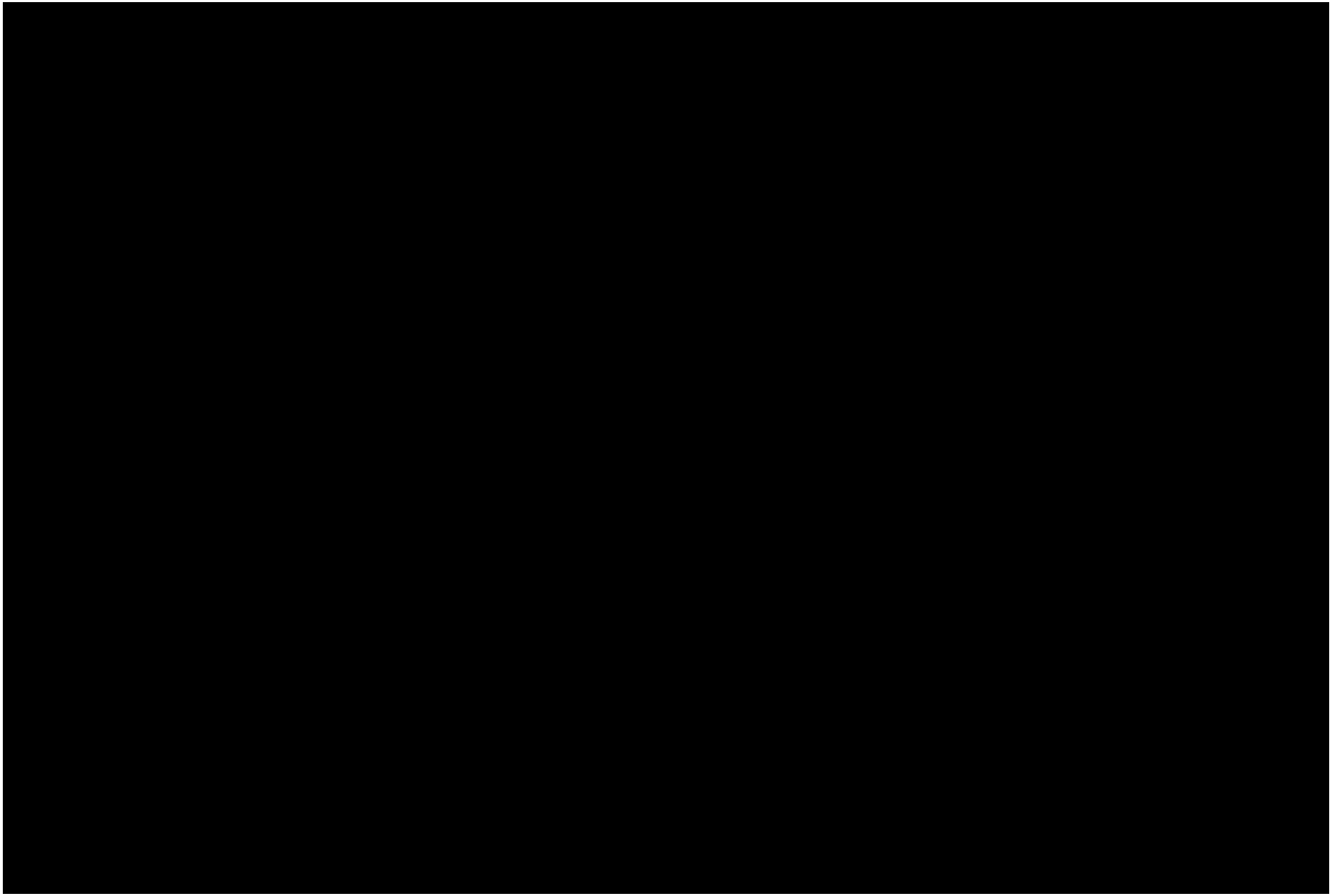
ID	Category	Metric Description	Type	Month
Field #	Network	Metric		Mar-22
6.1	Network	Number of new providers	#	
6.2	Network	Number of lost providers	#	
6.3	Network	Number of providers net-change	#	
6.4	Network	Percentage change in provider count	%	
6.5	Network	Number of providers in-network	#	
6.6	Network	Number of new locations	#	
6.7	Network	Number of lost locations	#	
6.8	Network	Number of locations net-change	#	
6.9	Network	Percentage of change in location count	%	
6.10	Network	Number of locations	#	
6.11	Network	Number of general providers on panel	#	
6.12	Network	Number of specialist providers on panel	#	
6.13	Network	Percentage of members with access to a general provider	%	
6.14	Network	Percentage of members with access to a specialist provider	%	
6.16	Network	Percentage of members without access to a general provider	%	
6.17	Network	Percentage of members without access to a specialist provider	%	
Field #	Claims	Metric		Mar-22
7.1	Claims	Number of All Claims Processed	#	
7.2	Claims	Number of Processed Claims per 1K Members	#	
7.3	Claims	Amount Billed for All Claims Processed	$	
7.4	Claims	Number of Claims Paid	#	
7.5	Claims	Amount Paid for Processed Claims	$	
7.6	Claims	Paid vs. Billed Ratio	#	
7.7	Claims	Number of Fully Approved Claims	#	
7.8	Claims	Number of Partially Approved Claims	#	
7.9	Claims	Number of Denied Claims	#	
7.10	Claims	Percentage of Denied Claims	%	
7.11	Claims	Amount Billed for Denied Claims	$	
7.12	Claims	Number of Clean Claims Processed	#	
7.13	Claims	The Number of Clean Claims Processed within 7 Calendar Days	#	
7.14	Claims	Percentage of Clean Claims Processed within 7 Calendar Days	%	
7.15	Claims	The Number of Clean Claims Processed within 10 Calendar Days	#	

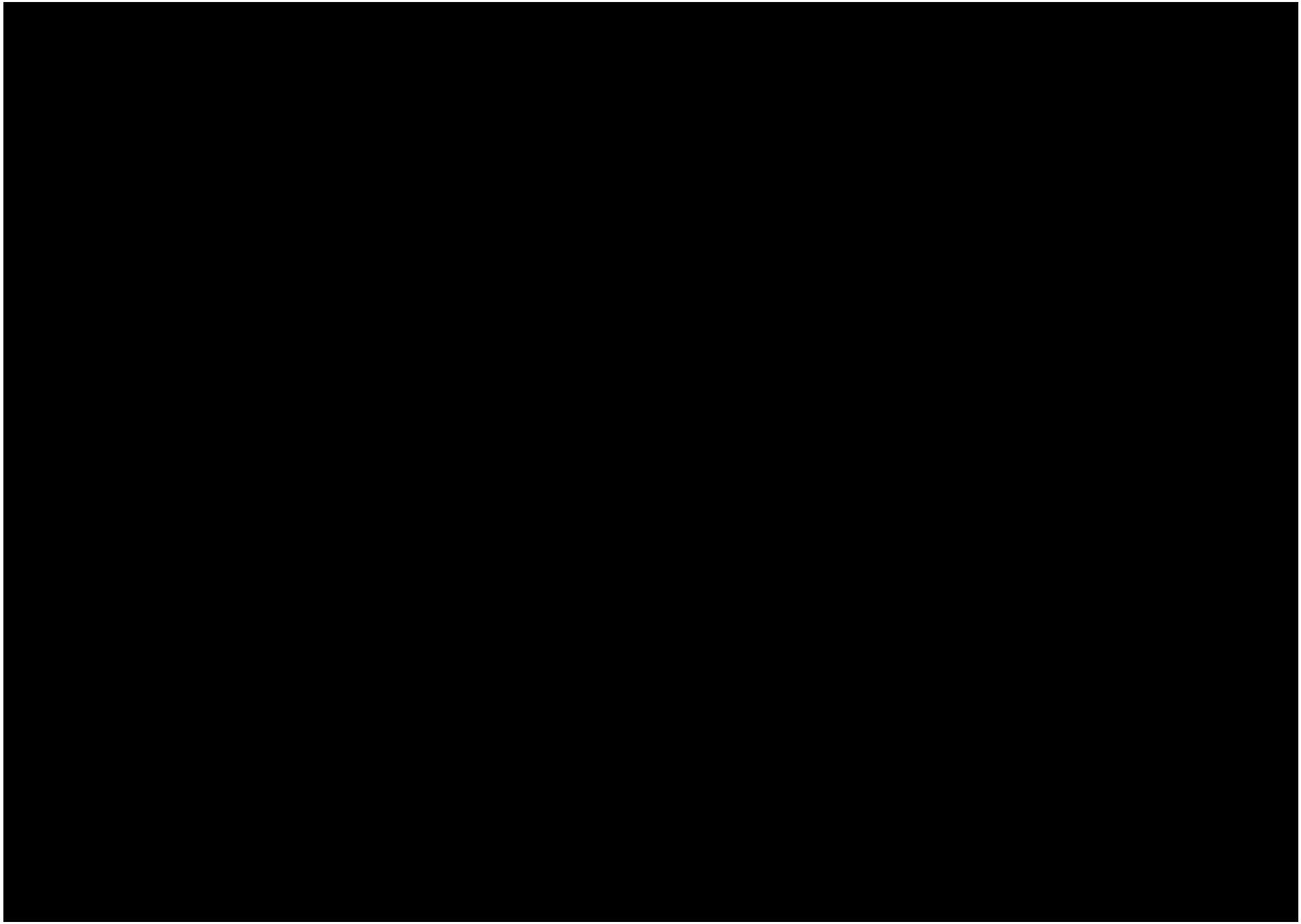
ID	Category	Metric Description	Type	Month
7.16	Claims	Percentage of Clean Claims Processed within 10 Calendar Days	%	
7.17	Claims	The Number of Clean Claims Processed within 15 Calendar Days	#	
7.18	Claims	Percentage of Clean Claims Processed within 15 Calendar Days	%	
7.19	Claims	The Number of Clean Claims Processed within 20 Calendar Days	#	
7.20	Claims	Percentage of Clean Claims Processed within 20 Calendar Days	%	
7.21	Claims	The Number of Clean Claims Processed within 30 Calendar Days	#	
7.22	Claims	Percentage of Clean Claims Processed within 30 Calendar Days	%	
7.23	Claims	The Number of Clean Claims Processed within 45 Calendar Days	#	
7.24	Claims	Percentage of Clean Claims Processed within 45 Calendar Days	%	
7.25	Claims	The Number of Clean Claims Processed within 60 Calendar Days	#	
7.26	Claims	Percentage of Clean Claims Processed within 60 Calendar Days	%	
7.27	Claims	The Number of Clean Claims Processed in more than 60 Calendar Days	#	
7.28	Claims	Percentage of Clean Claims Processed in more than 60 Calendar Days	%	
Field #	**Provider Calls**	**Metric**		**Mar-22**
8.1	Provider Calls	Number of calls received	#	
8.2	Provider Calls	Number of calls abandoned	#	
8.3	Provider Calls	Percentage of calls abandoned	%	
8.4	Provider Calls	Number of calls answered	#	
8.5	Provider Calls	Number of calls answered within 10 seconds	#	
8.6	Provider Calls	Percentage of calls answered in 10 seconds	%	
8.7	Provider Calls	Number of calls answered in 20 seconds	#	
8.8	Provider Calls	Percentage of calls answered in 20 seconds	%	
8.9	Provider Calls	Number of calls answered in 30 seconds	#	
8.10	Provider Calls	Percentage of calls answered in 30 seconds	%	
8.11	Provider Calls	Number of calls answered in 45 seconds	#	
8.12	Provider Calls	Percentage of calls answered in 45 seconds	%	
8.13	Provider Calls	Number of calls answered in 60 seconds	#	
8.14	Provider Calls	Percentage of calls answered in 60 seconds	%	
8.15	Provider Calls	Number of calls answered in 90 seconds	#	
8.16	Provider Calls	Percentage of calls answered in 90 seconds	%	
8.17	Provider Calls	Average Speed to Answer in seconds (mm:ss)	mm:ss	
8.18	Provider Calls	Average Talk Time (mm:ss)	mm:ss	
8.19	Provider Calls	Number of calls put on hold	#	

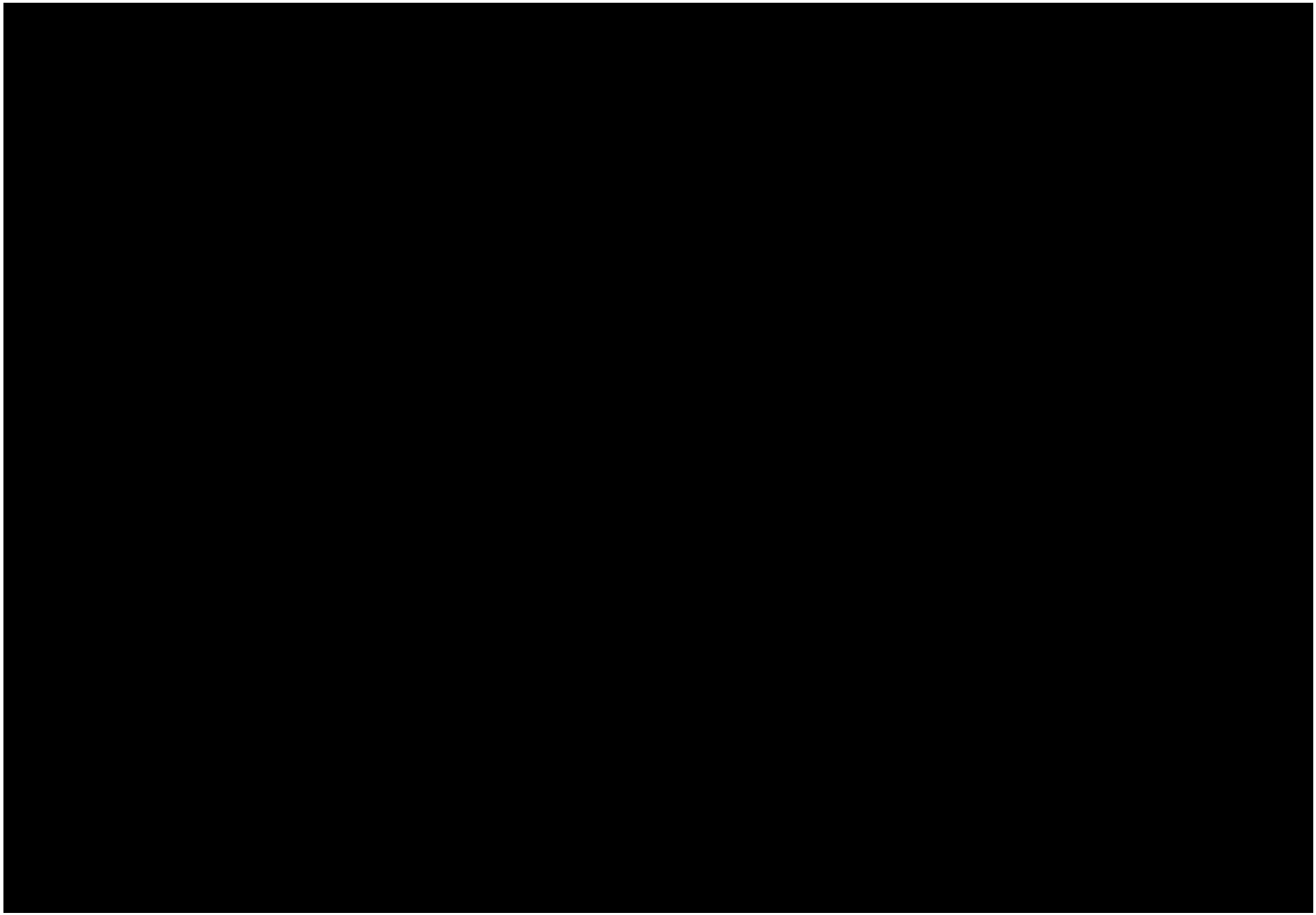
ID	Category	Metric Description	Type	Month
8.20	Provider Calls	Average time on hold (mm:ss)	mm:ss	
8.21	Provider Calls	Blocked Calls	#	
8.22	Provider Calls	Percentage of Blocked Calls	%	
8.23	Provider Calls	Calls getting a Busy Signal	#	
8.24	Provider Calls	Percentage of Calls getting a Busy Signal	%	
8.25	Provider Calls	Number of calls per 1k members	#	
Field #	**Member Calls**	**Metric**		**Mar-22**
9.1	Member Calls	Number of calls received	#	
9.2	Member Calls	Number of calls abandoned	#	
9.3	Member Calls	Percentage of calls abandoned	%	
9.4	Member Calls	Number of calls answered	#	
9.5	Member Calls	Number of calls answered within 10 seconds	#	
9.6	Member Calls	Percentage of calls answered in 10 seconds	%	
9.7	Member Calls	Number of calls answered in 20 seconds	#	
9.8	Member Calls	Percentage of calls answered in 20 seconds	%	
9.9	Member Calls	Number of calls answered in 30 seconds	#	
9.10	Member Calls	Percentage of calls answered in 30 seconds	%	
9.11	Member Calls	Number of calls answered in 45 seconds	#	
9.12	Member Calls	Percentage of calls answered in 45 seconds	%	
9.13	Member Calls	Number of calls answered in 60 seconds	#	
9.14	Member Calls	Percentage of calls answered in 60 seconds	%	
9.15	Member Calls	Number of calls answered in 90 seconds	#	
9.16	Member Calls	Percentage of calls answered in 90 seconds	%	
9.17	Member Calls	Average Speed to Answer in seconds (mm:ss)	mm:ss	
9.18	Member Calls	Average Talk Time (mm:ss)	mm:ss	
9.19	Member Calls	Number of calls put on hold	#	
9.20	Member Calls	Average time on hold (mm:ss)	mm:ss	
9.21	Member Calls	Blocked Calls	#	
9.22	Member Calls	Percentage of Blocked Calls	%	
9.23	Member Calls	Calls getting a Busy Signal	#	
9.24	Member Calls	Percentage of Calls getting a Busy Signal	%	
9.25	Member Calls	Number of calls per 1k members	#	

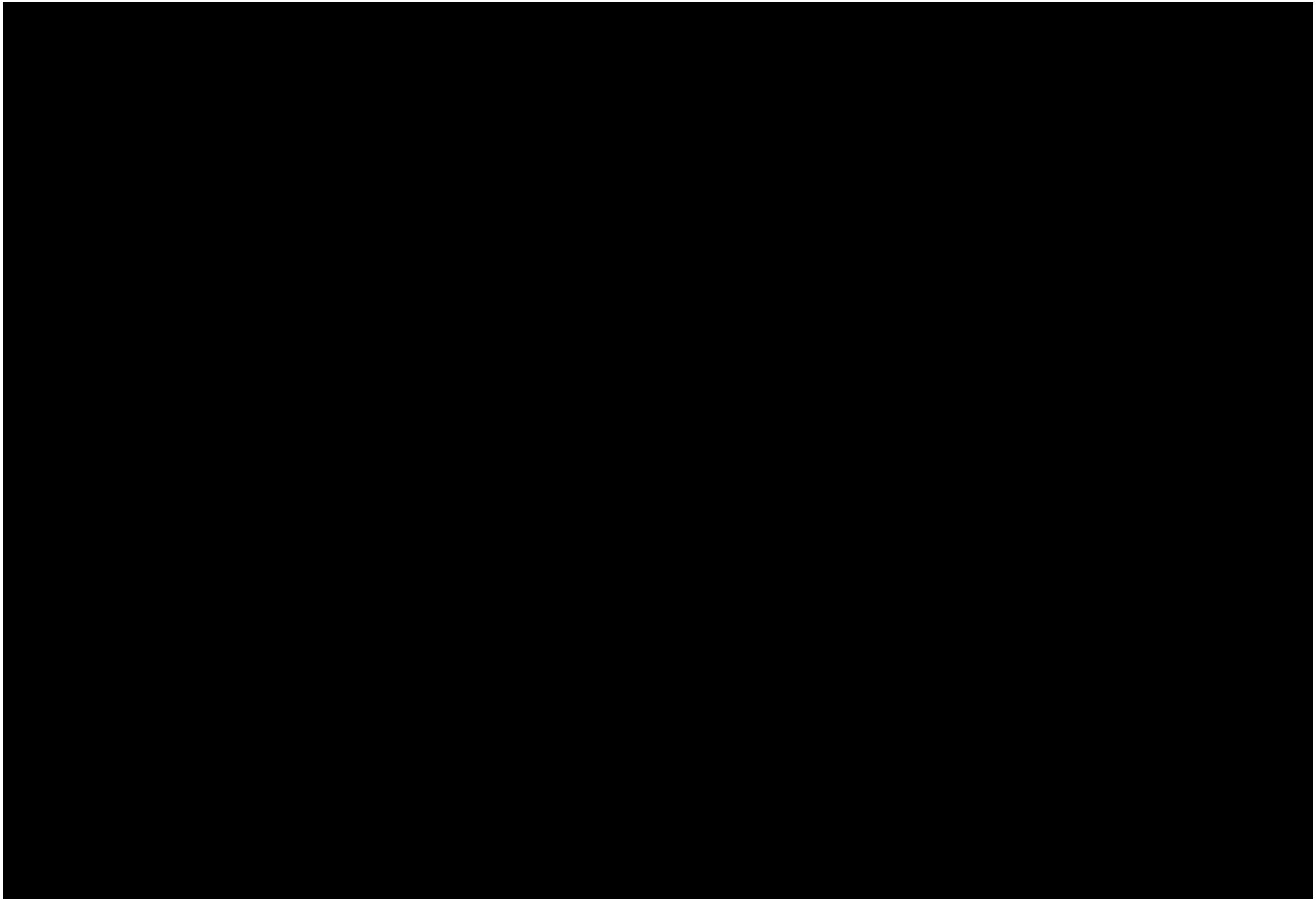
ID	Category	Metric Description	Type	Month
Field #	Provider Claim Appeals	Metric		Mar-22
10.1	Provider Claim Appeals	Number of written provider appeals	#	
10.2	Provider Claim Appeals	Number of provider appeals resolved within 20 business days	#	
10.3	Provider Claim Appeals	Percentage of provider appeals resolved within 20 business days	%	
10.4	Provider Claim Appeals	Number of provider appeals resolved within 30 business days	#	
10.5	Provider Claim Appeals	Percentage of provider appeals resolved within 30 business days	%	
10.6	Provider Claim Appeals	Number of approved appeals	#	
10.7	Provider Claim Appeals	Number of denied appeals	#	
10.8	Provider Claim Appeals	Percentage of denied appeals	%	
Field #	Service Denials	Metric		Mar-22
11.1	Service Denials	Number of services adjudicated	#	
11.2	Service Denials	Number of denied services	#	
11.3	Service Denials	Percentage of Services Denied	%	
11.4	Service Denials	#1 Top service denial reason	abc	
11.5	Service Denials	#2 Top service denial reason	abc	
11.6	Service Denials	#3 Top service denial reason	abc	
11.7	Service Denials	#4 Top service denial reason	abc	
11.8	Service Denials	#5 Top service denial reason	abc	
11.9	Service Denials	#6 Top service denial reason	abc	
11.10	Service Denials	#7 Top service denial reason	abc	
11.11	Service Denials	#8 Top service denial reason	abc	
11.12	Service Denials	#9 Top service denial reason	abc	
11.13	Service Denials	#10 Top service denial reason	abc	
11.14	Service Denials	#1 Denial (Volume)	#	
11.15	Service Denials	#2 Denial (Volume)	#	
11.16	Service Denials	#3 Denial (Volume)	#	
11.17	Service Denials	#4 Denial (Volume)	#	
11.18	Service Denials	#5 Denial (Volume)	#	
11.19	Service Denials	#6 Denial (Volume)	#	
11.20	Service Denials	#7 Denial (Volume)	#	
11.21	Service Denials	#8 Denial (Volume)	#	
11.22	Service Denials	#9 Denial (Volume)	#	
11.23	Service Denials	#10 Denial (Volume)	#	

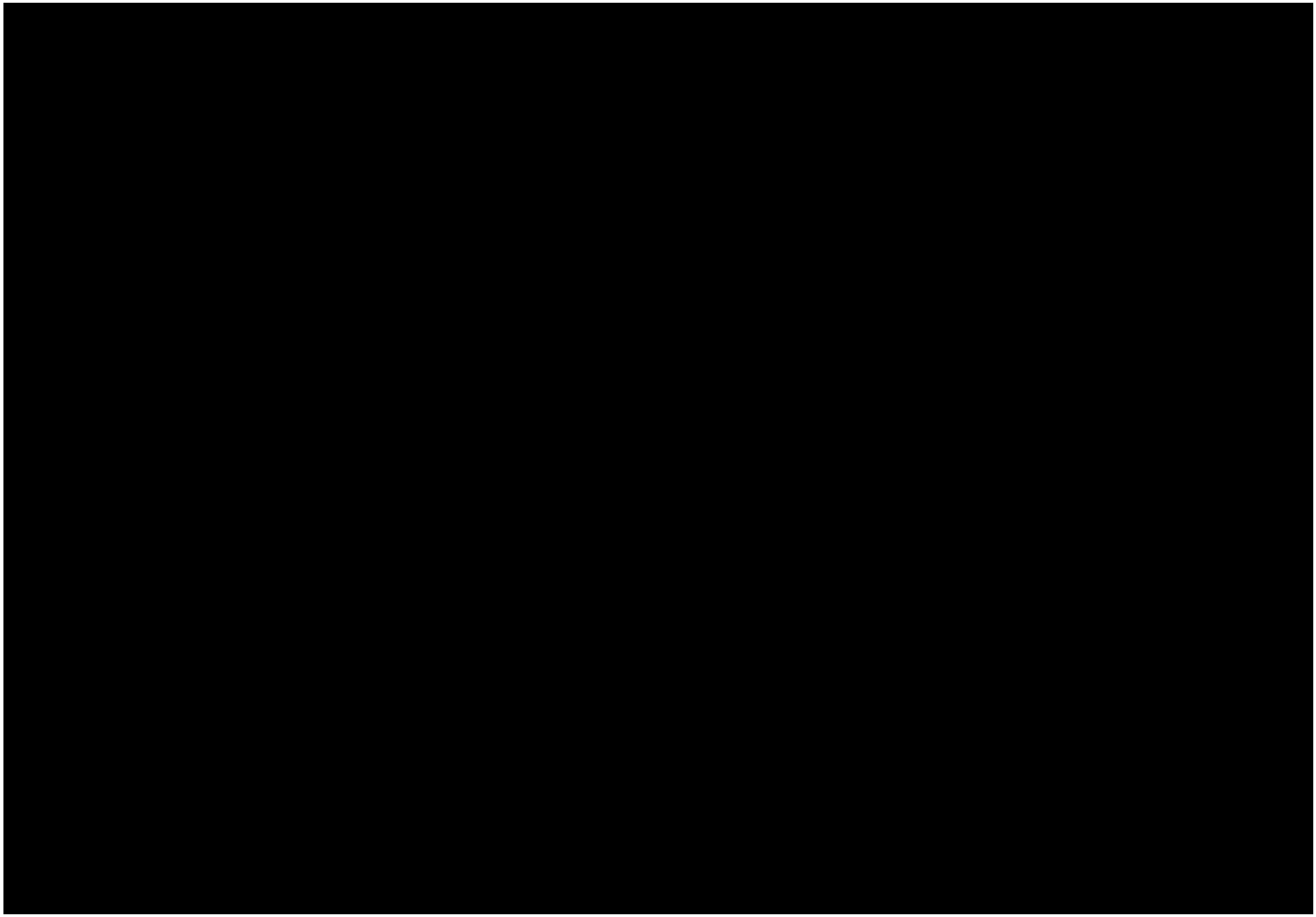
ID	Category	Metric Description	Type	Month
Field #	Authorizations	Metric		Mar-22
12.1	Authorizations	Total authorization requests determined	#	
12.2	Authorizations	Number of routine requests determined	#	
12.3	Authorizations	Number of Retro Authorization Requests Determined	#	
12.4	Authorizations	Number of Urgent Authorization Requests Determined	#	
12.5	Authorizations	Urgent authorization request benchmark	#	
12.6	Authorizations	Number of urgent authorizations processed on-time	#	
12.7	Authorizations	Percentage of Urgent Authorizations on Time	%	
12.8	Authorizations	Urgent request turnaround time (Hours)	#	
12.9	Authorizations	Routine authorization request benchmark	#	
12.10	Authorizations	Number of routine authorizations determined on-time	#	
12.11	Authorizations	Percentage of Routine Authorizations on Time	%	
12.12	Authorizations	Routine request turnaround time (Days)	#	
12.13	Authorizations	Number of requested services determined	#	
12.14	Authorizations	Total requested services denied	#	
12.15	Authorizations	Percentage of requested services denied	%	
12.16	Authorizations	Number of requested services denied for administrative	#	
12.17	Authorizations	Percentage of requested services denied for administrative	%	
12.18	Authorizations	Number of requested services denied for clinical	#	
12.19	Authorizations	Percentage of requested services denied for clinical	%	
12.20	Authorizations	#1 Top service denial reason	abc	
12.21	Authorizations	#2 Top service denial reason	abc	
12.22	Authorizations	#3 Top service denial reason	abc	
12.23	Authorizations	#4 Top service denial reason	abc	
12.24	Authorizations	#5 Top service denial reason	abc	

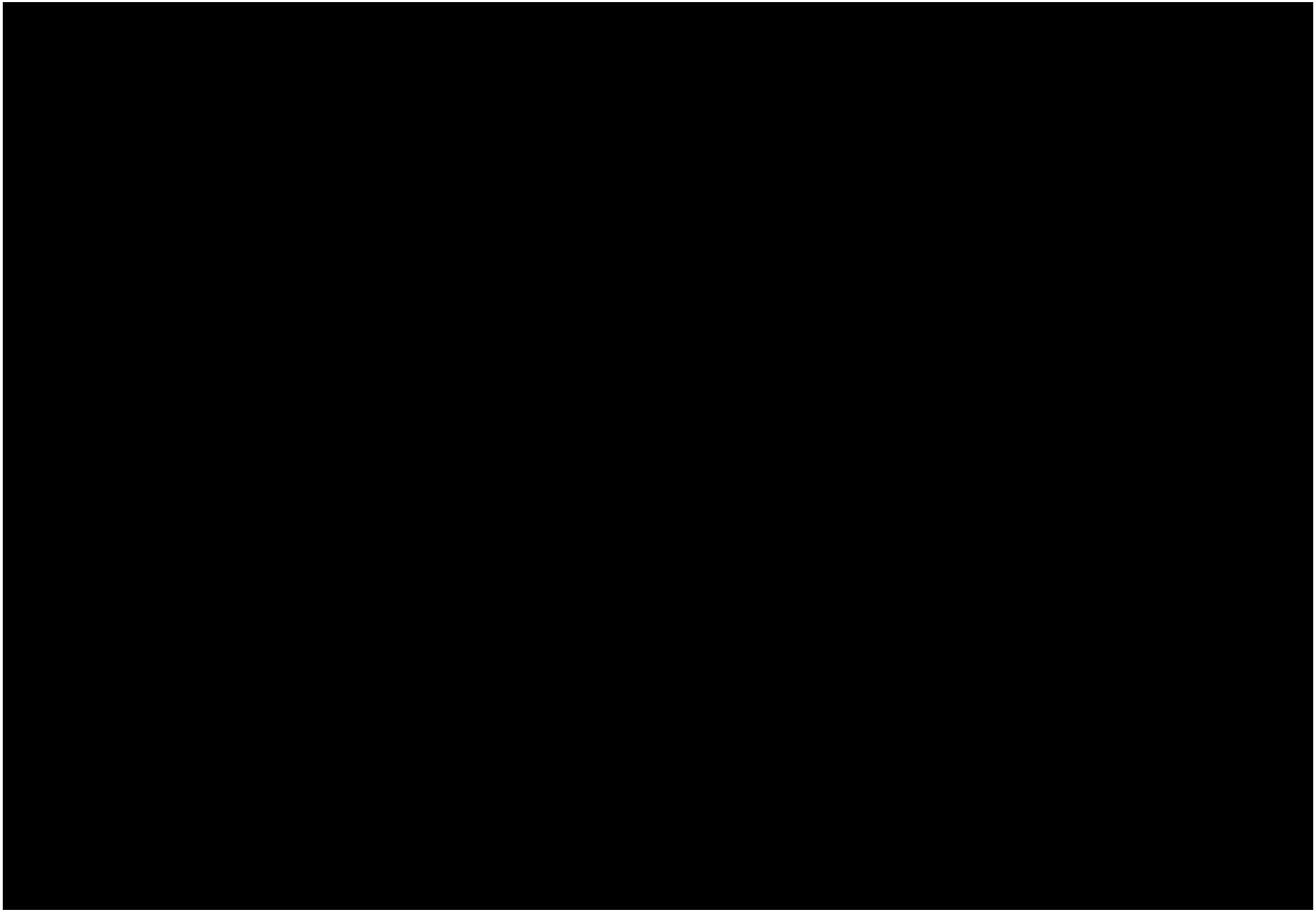












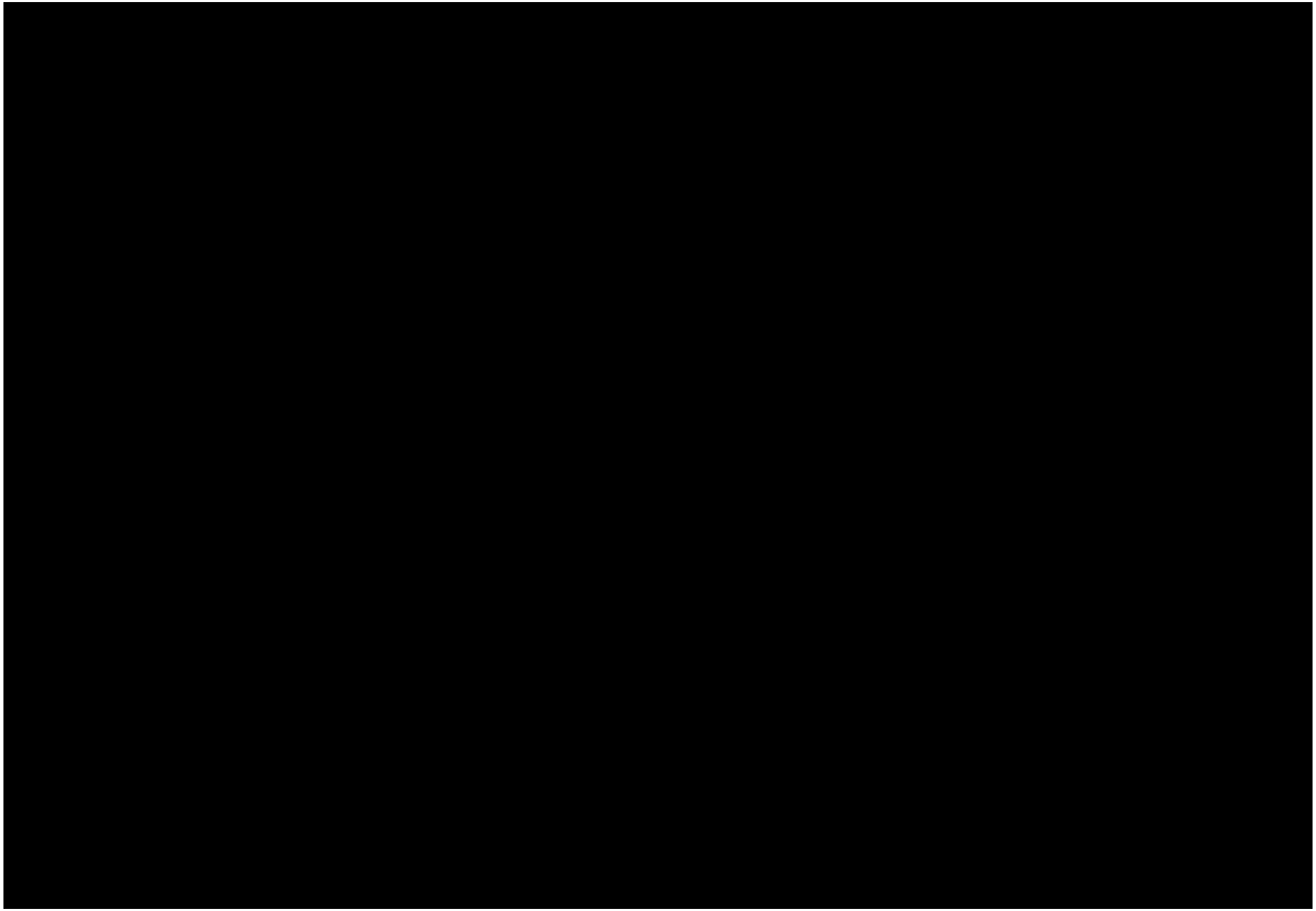


Figure 111.K. Example Leading Indicators Executive Portal Dashboards

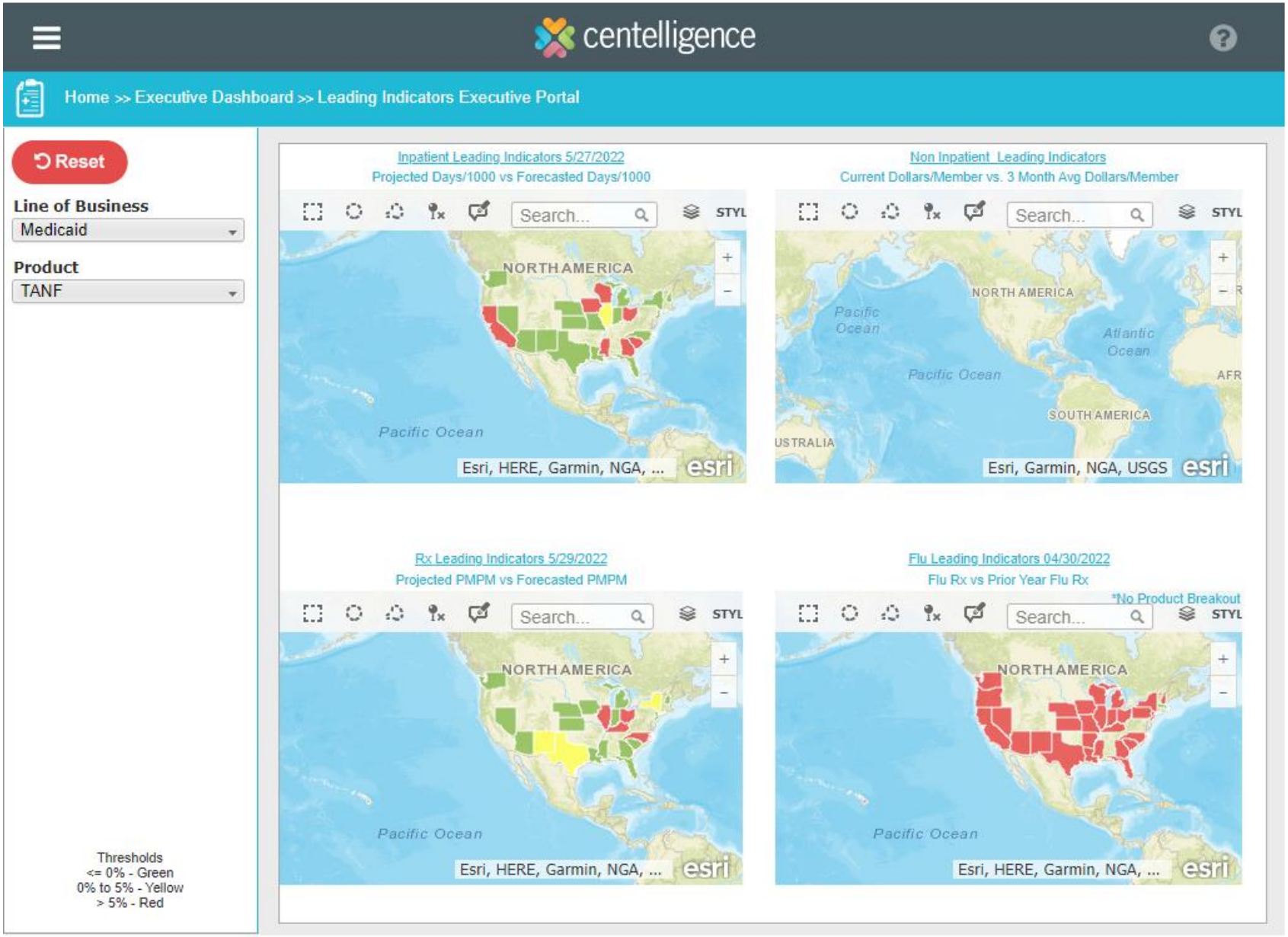
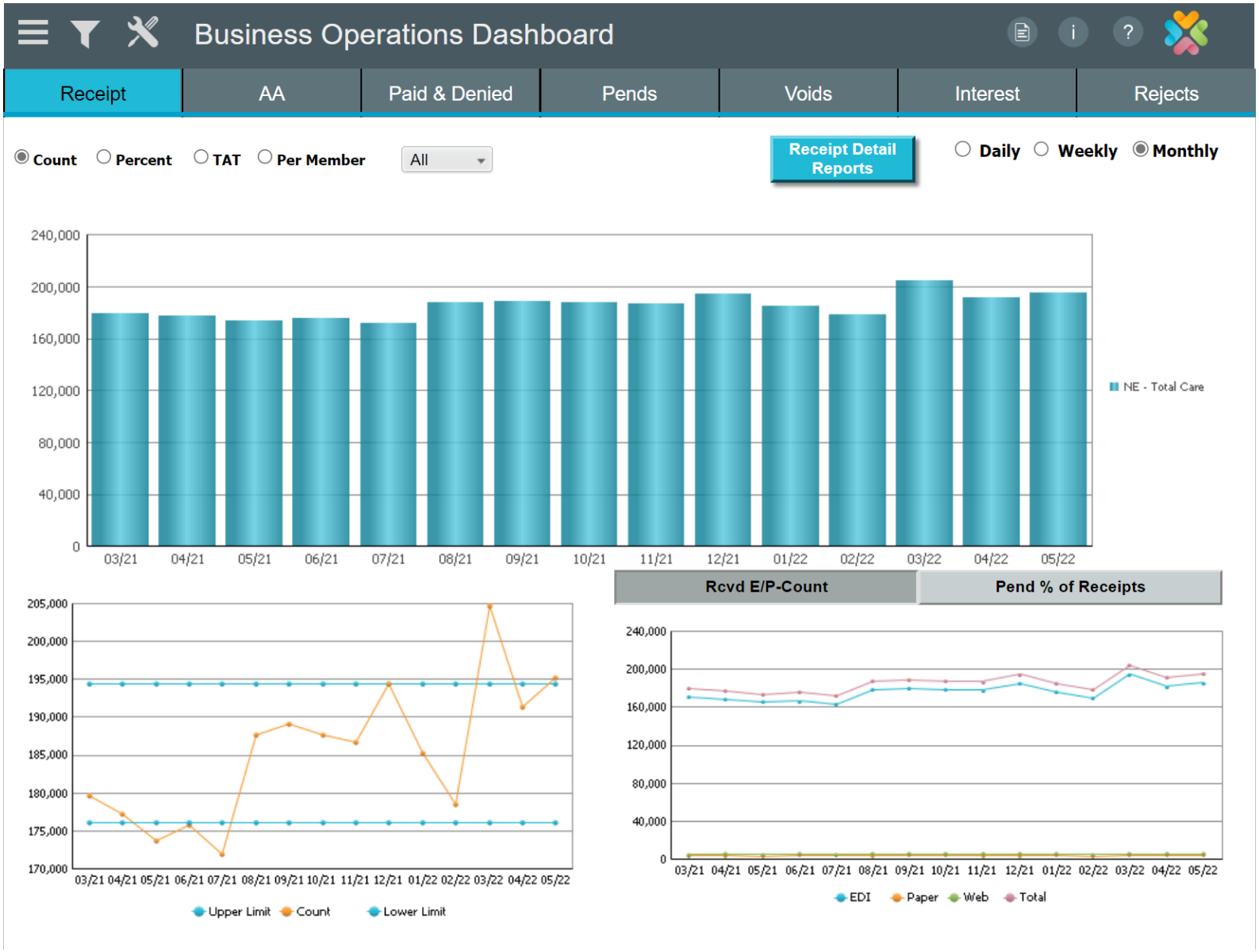
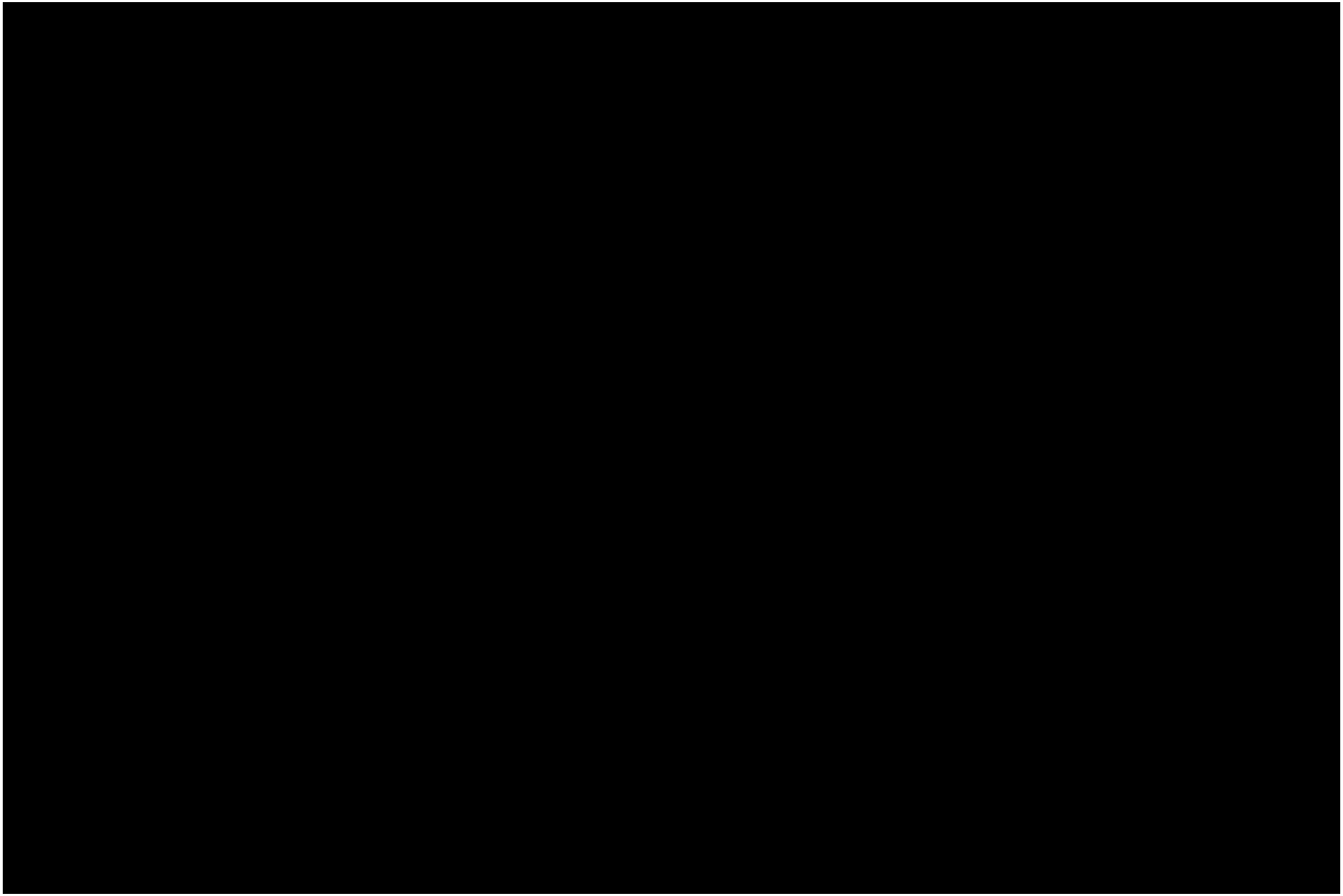
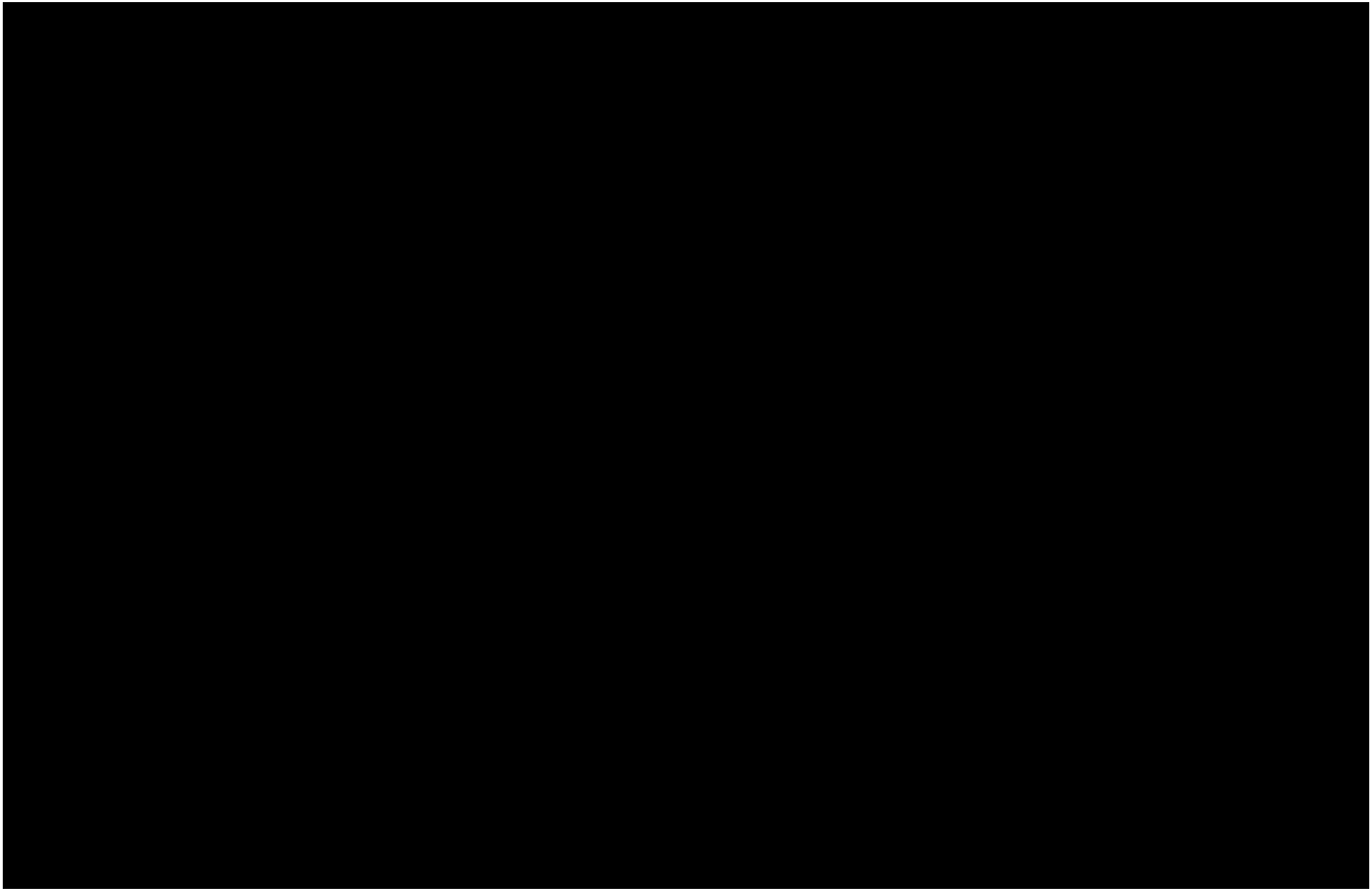


Figure 111.L. Example Business Operations Dashboard







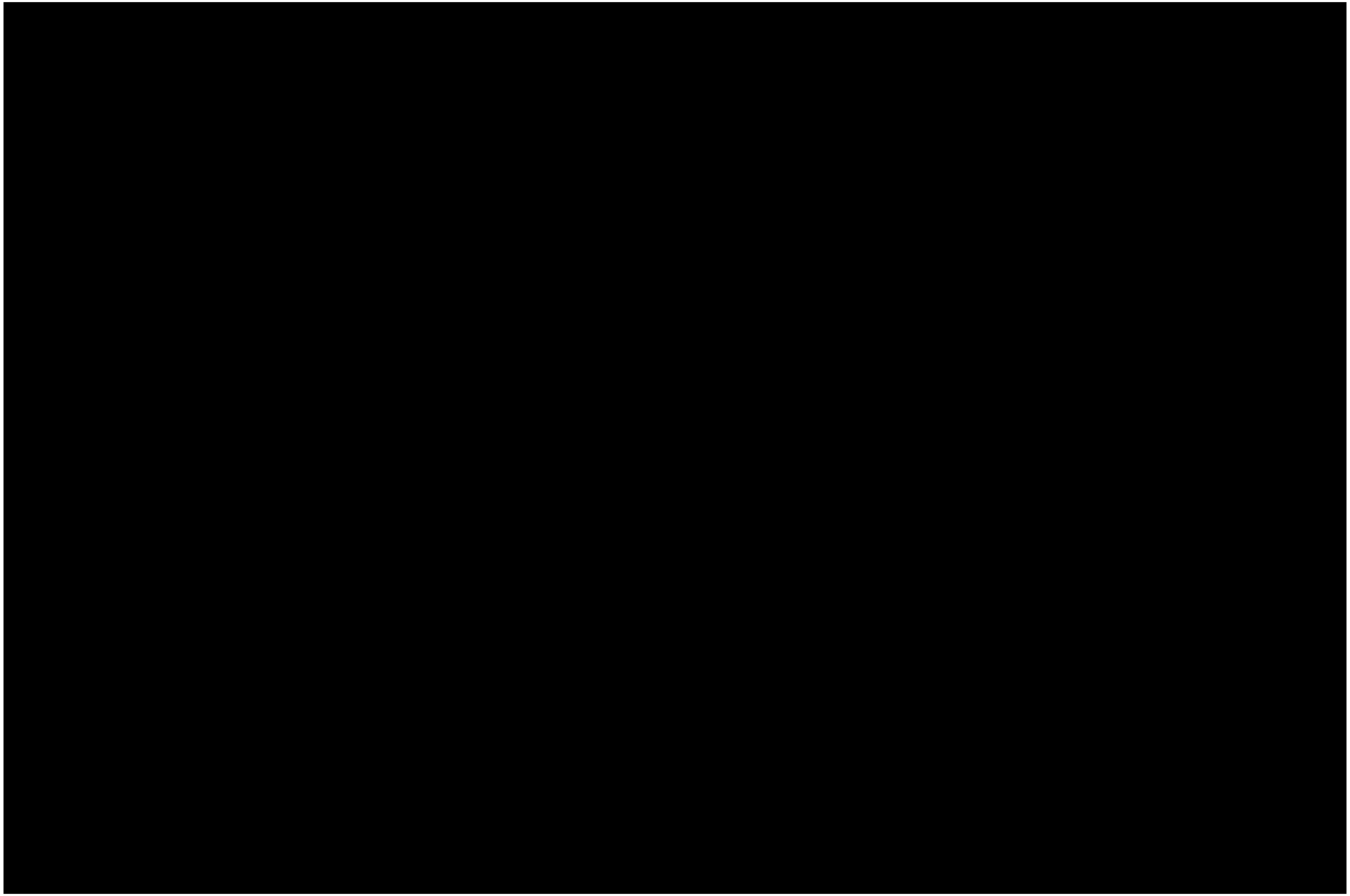


Figure 111.N. Example Encounters Dashboard

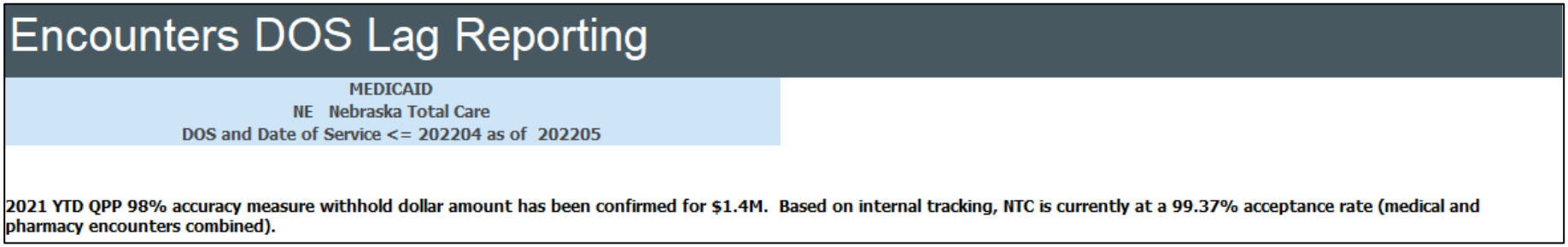
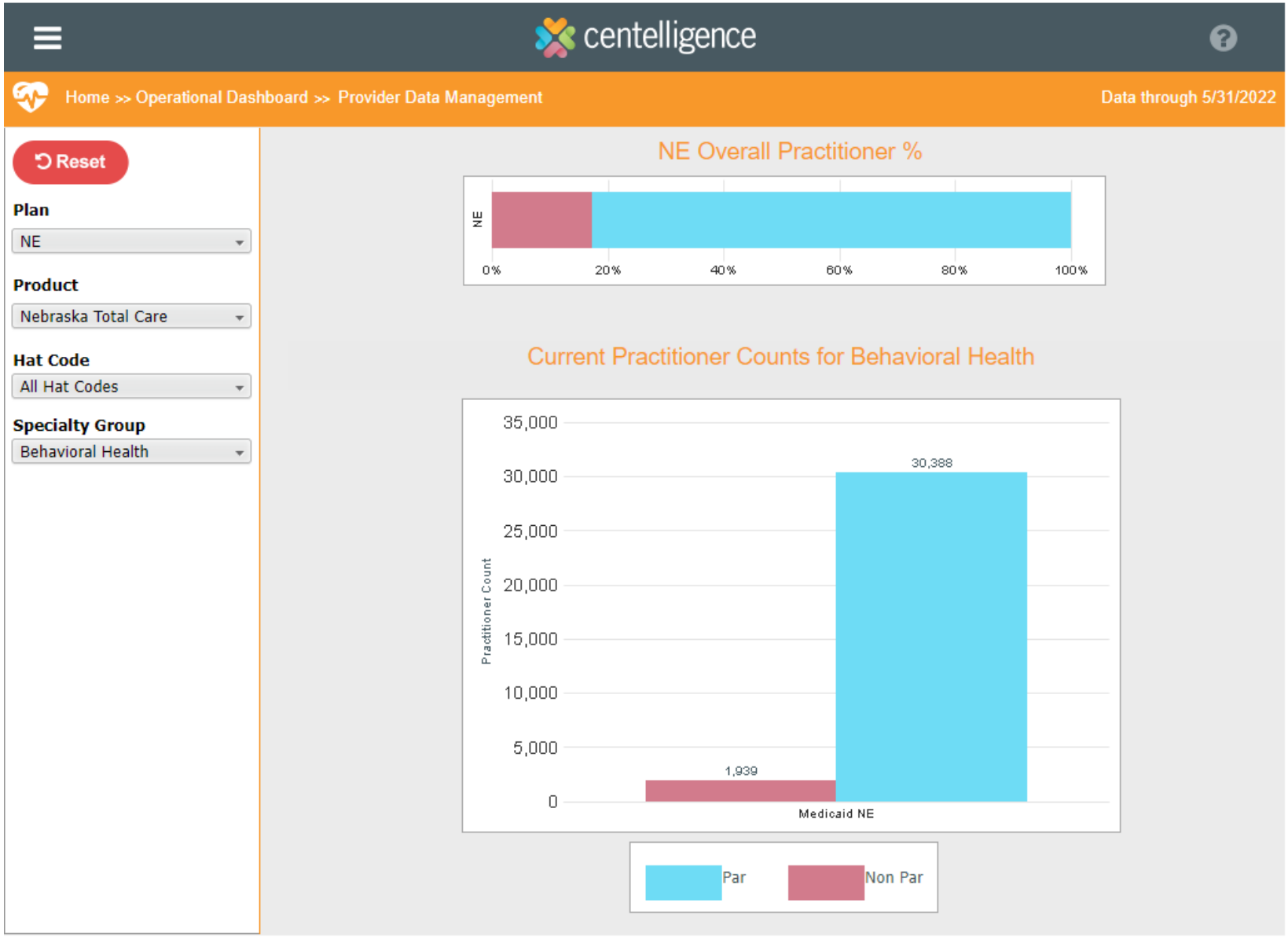


Figure 111.O. Example Provider Dashboard

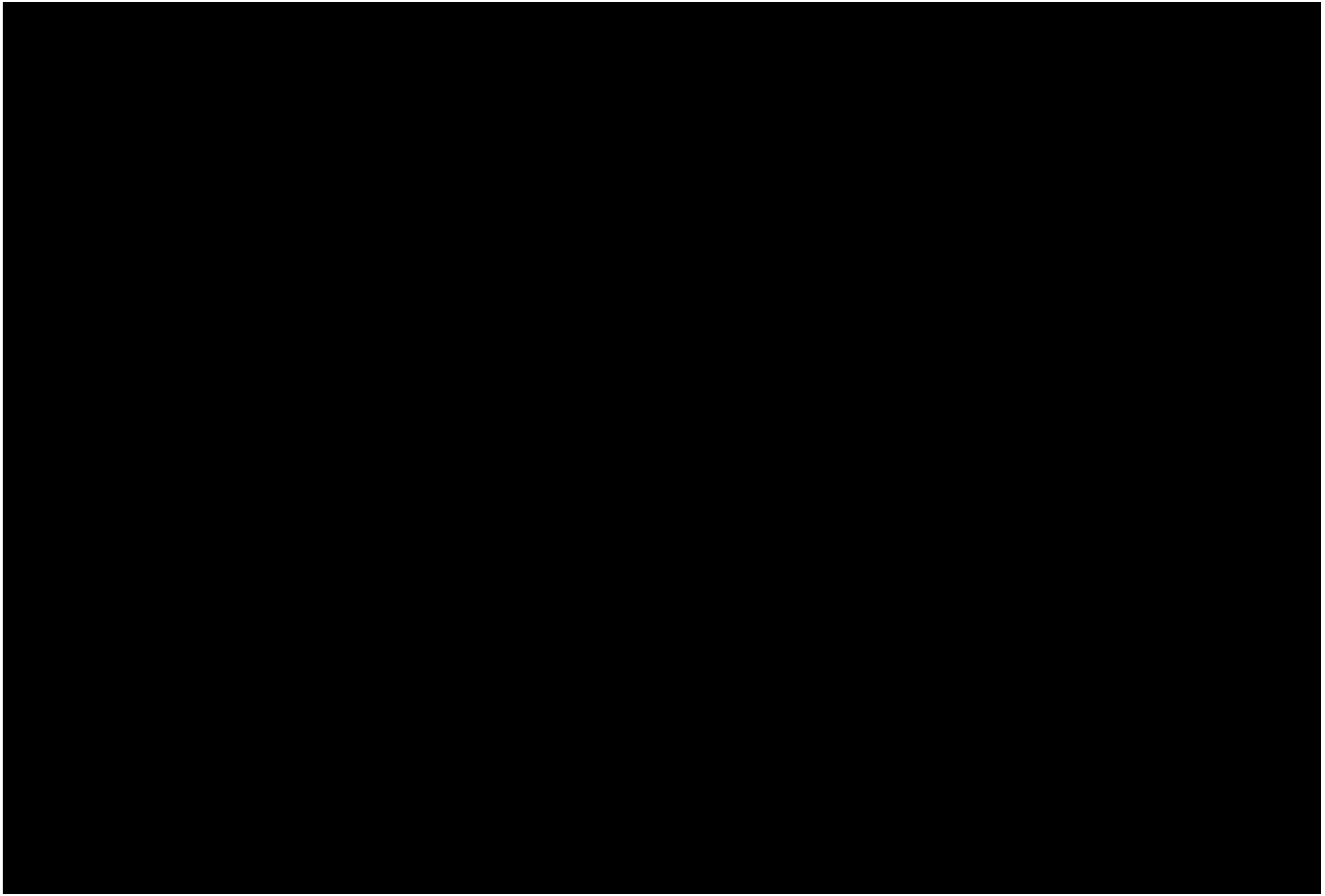


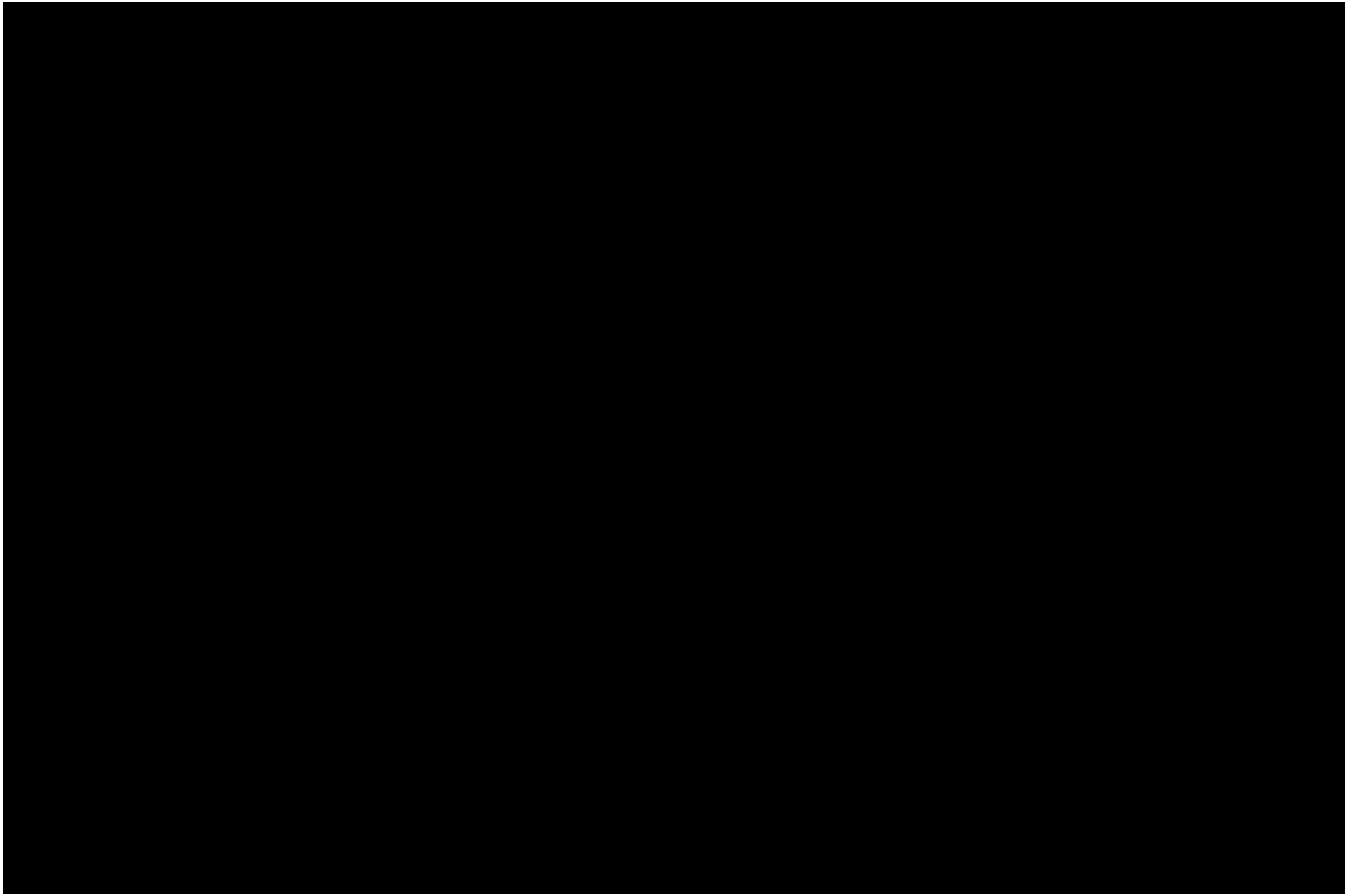
Dashboards Used by QAPI Committee and its Sub-Committees to Monitor Performance

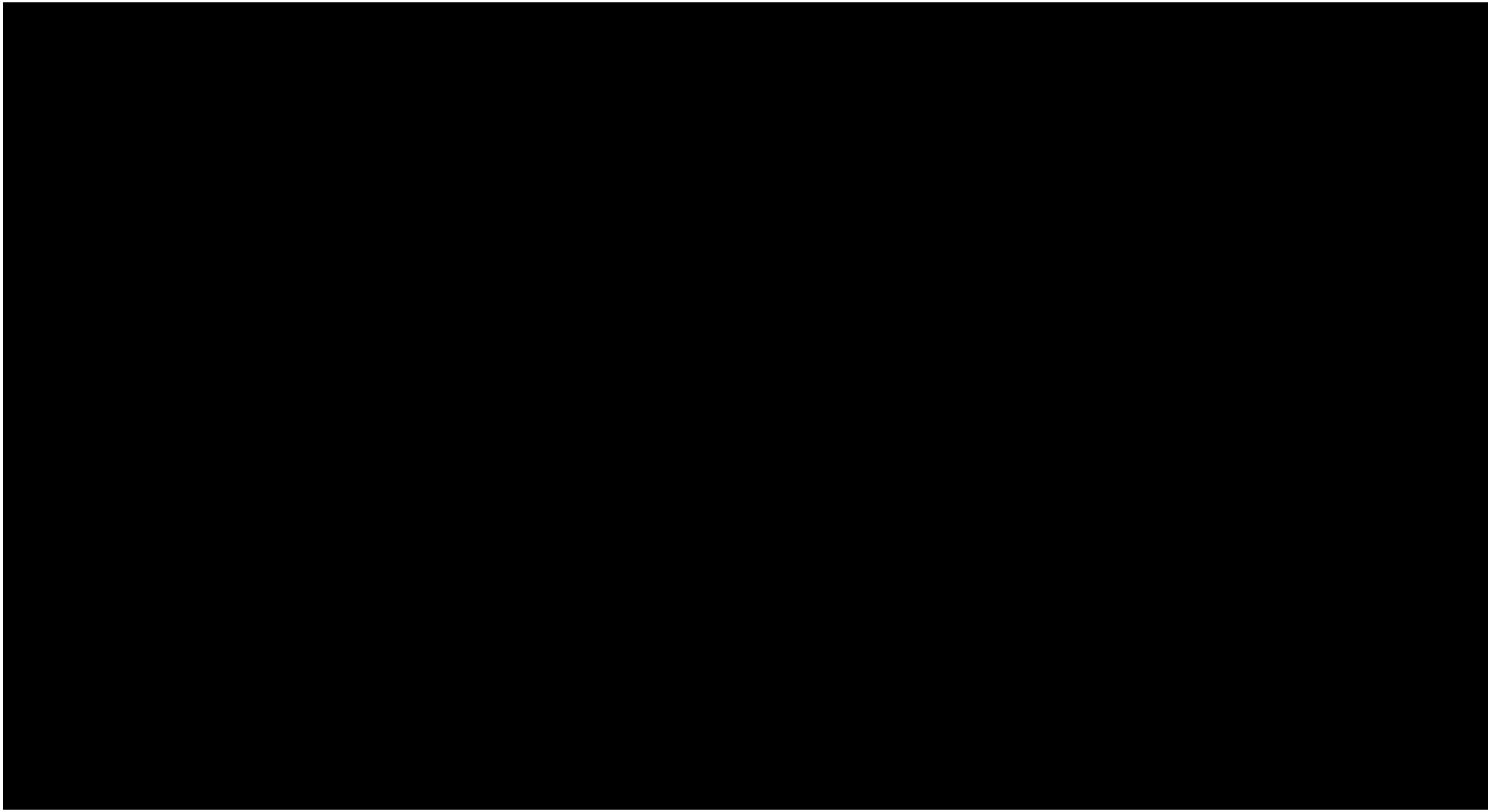
An overview of dashboards used by our QAPI Committee, and its sub-committees are included in Table 111.D and depicted in Figures 111.P through 111.U. For purposes of this RFP, we have identified dashboards predominantly utilized by either leadership or the QAPI committee, but members of each group have access to all these dashboards and reports. Additional dashboards not shown include Care Management Dashboard, Population Health Dashboard, CARE Satisfaction Dashboard, Authorization Dashboard, Medical Director Dashboard, Rx Leading Indicators Dashboard, Specialty Drug Dashboard, Neonate Leading Indicators Dashboard and Start Smart for Your Baby Predictive Analytics Tools.

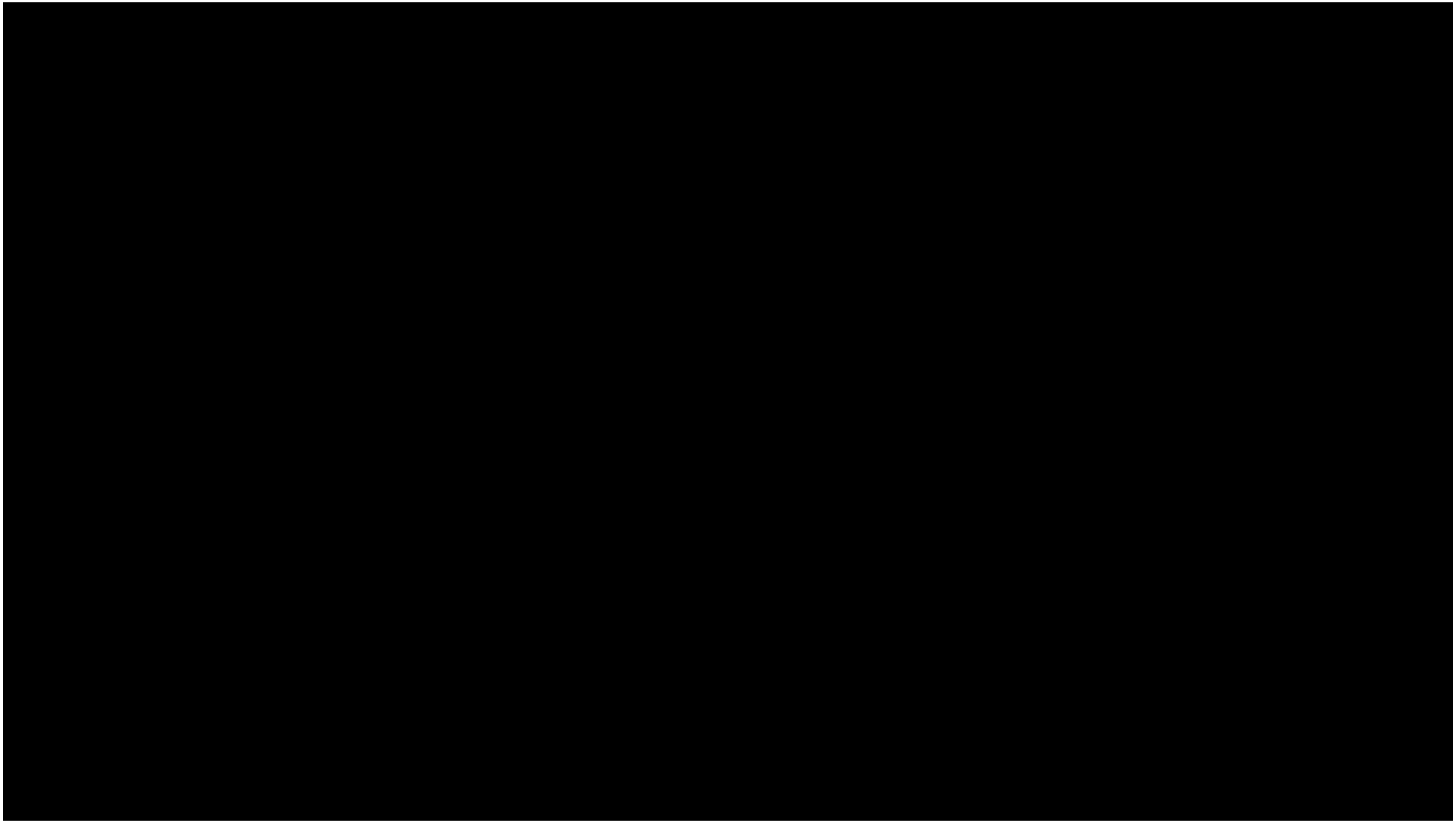
Table 111.D. QAPI Committee Dashboard Overview

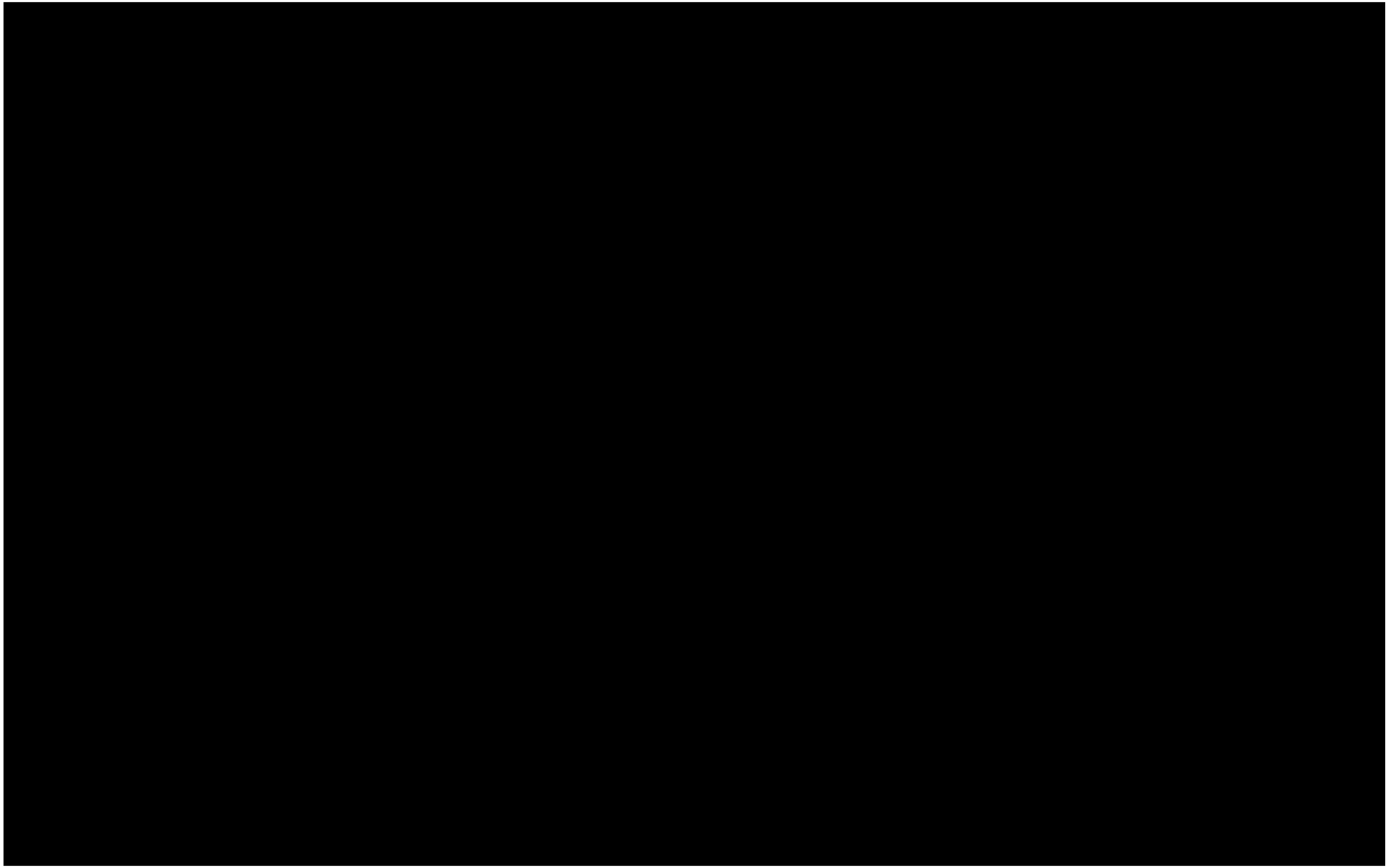
Figure Number	Dashboard Name	Description
111.P	Health Equity Dashboard	This dashboard is used to understand HEDIS measures that have disproportionate outcomes based upon a member's age, race or other demographics. The dashboard allows the user to drill down into data to develop action plans that improve outcomes and create equity.
111.Q	SDOH KPI Dashboard	Dashboard is used to understand the SDOH impacting Nebraska Total Care's members by geographic, race, ethnicity, and other demographic factors. The QAPI Committee reviews and approves Nebraska Total Care's SDOH macro strategy in support of improving member health outcomes and creating health equity.
111.R	Health Benefits Ratio Dashboard	Dashboard with drill-down capability, used by Nebraska Total Care leadership team and QAPI Committee to understand its medical loss ratio for the plan over a period of time and the key factors contributing to that health benefits ratio (medical loss ratio). Underlying data is analyzed to determine if different approaches need to be taken to contain costs or drive more utilization of proactive health services.
111.S	Quality Dashboards	Overview of HEDIS measures with drill-down capability, used by QAPI Committee to understand year-to-date performance on individual HEDIS measures and compare that performance to prior years, projected HEDIS percentiles and projected STARS performance levels. This data is used to adjust action plans to improve member health outcomes and increase Nebraska Total Care's HEDIS and STARS performance.
111.T	Grievance and Appeals Dashboard	This report provides operational KPIs for the grievance and appeals area. The QAPI Committee monitors timeliness, average turnaround times, overturn percentages, and volume of grievances and complaints to ensure Nebraska Total Care remains compliant with regulations and contractual obligations. This report is used as a point of reference to gauge overall member and provider satisfaction and emerging grievance and appeals trends.
111.U	Credentialing Report	This report provides operational KPIs for the credentialing area. The QAPI Committee monitors timeliness, average turnaround times, volume of providers credentialed, and sanction status to ensure Nebraska Total Care remains compliant with regulations and uses these statistics as a point of reference for member and provider satisfaction.











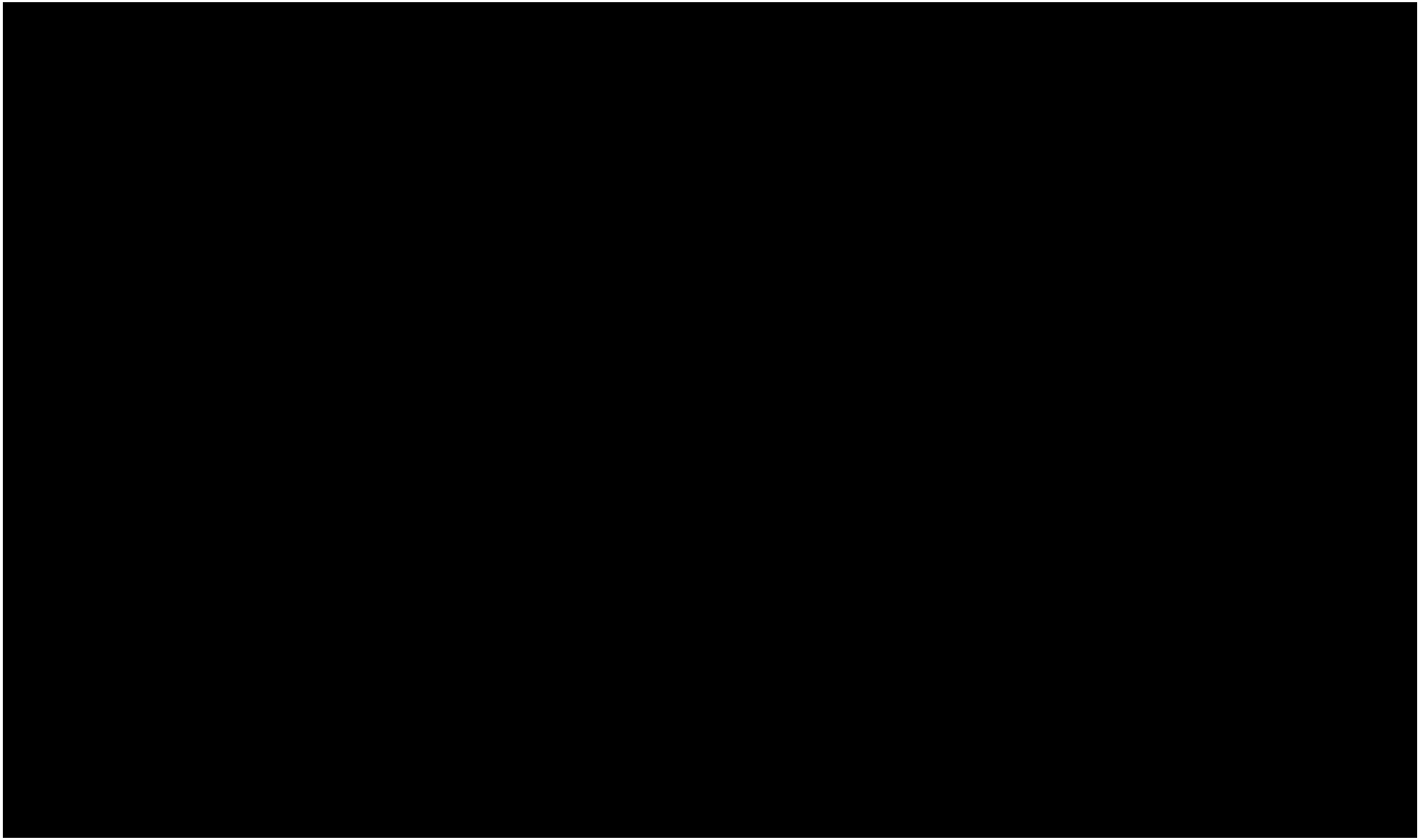


Figure 111.S. Quality Dashboards

QDAR
Quality Data Analytics and Reporting

	2019 HEDIS Actuals	2020 HEDIS Actuals	2021 HEDIS/CY20		2022 HEDIS/CY21						
Chapter	HED19/CY18 Final STAR	HED20/CY19 Final STAR	CY20 Final Unrounded STAR	CY20 Final Rounded STAR*	1 Yr Ago YTD Unrounded STAR	Current YTD Unrounded STAR	CY20 YTD to CY21 YTD Unrounded STAR Trend	CY21 Proj EOY Unrounded STAR	CY21 Proj EOY Rounded STAR	CY20 Unrounded STAR to CY21 Proj Unrounded STAR Trend	CY20 Rounded STAR to CY21 Proj Rounded STAR Trend
CAHPS	N/A	2.71	4.87	5.00	4.87	4.87	0.00	4.87	5.00	0.00	0.00
HEDIS BH	N/A	2.90	3.20	3.00	3.05	2.82	-0.23	3.40	3.50	0.20	0.50
HEDIS Clinical	N/A	2.55	2.86	3.00	1.69	1.68	-0.01	3.24	3.00	0.38	0.00
HEDIS RX	N/A	3.00	3.50	3.50	3.50	3.69	0.19	3.75	4.00	0.25	0.50
OVERALL	**N/A**	**3.63**	**3.91**	**4.00**	**3.29**	**3.24**	-0.06	**4.16**	**4.00**	0.26	0.00
Consumer Satisfaction	N/A	4.20	4.86	5.00	4.86	4.86	0.00	4.86	5.00	-0.01	0.00
Prevention	N/A	2.58	2.64	2.50	1.79	1.88	0.08	2.91	3.00	-0.29	0.00
Treatment	N/A	3.09	3.22	3.00	2.53	2.44	-0.09	3.33	3.50	0.47	0.50

This dashboard allows the user to drill down into specific HEDIS and CAHPS performance measures to identify opportunities for improvement.

Figure 111.U. Credentialing Report

Nebraska Total Care Credentialing Report

	Q1 2022
Initial Credentialing (1/1/2022 to 3/31/2022	
Number of practitioners credentialied within 30day timeline	270
Recredentialing	
Number of practitioners re-credentialied within 36 month timeline	206
Terminated/Rejected/Suspended/Denied	0
Number with Cause	0
Ongoing Monitoring	0
Date and staff member reviewing license sanctioning report by licensing entity	1/17/2022, 2/28/2022 / Lynsey Kral
Date and staff member reviewing Medicare and Medicaid Sanctions Information	1/17/2022, 2/10/2022 / Lynsey Kral
Number of Practitoners in network identified as having new sanctions for State License and Medicaid/Medicaid sanctions in reporting period	

	On-Time Percent
Practitioner Recredentialing Success Report	January-March
Nebraska Total Care	100%

	Average TAT (From Completed App)
Practitioner credentialing Success Report	January-March
Nebraska Total Care	2.16

RFP 112209 O3

B. Technical Approach

V.X Transition and Implementation

V.X Transition and Implementation

112. Describe how the Bidder will coordinate the initial transition of individuals in the following situations to ensure continuity of care:
• From another MCO.
• From FFS.
Include processes for engaging existing providers in the transition.
Page Limit: 5

Coordinating Initial Transitions to Promote Continuity of Care

Nebraska Total Care facilitates continuity of care for members that transition into our plan and will leverage our experience from the initial launch of Heritage Health transitions of care operations in 2017. We sustain an integrated, well-coordinated service delivery system for members to facilitate continuity of care as they transition between various Nebraska MCOs and from FFS. The dedicated Transition of Care (TOC) Coordinator serves as the key point of contact between Nebraska Total Care, State agencies, MLTC, the member, caregivers, and providers. The TOC Coordinator integrates all efforts to coordinate, manage, and ensure continuity of care.

During the initial 180 calendar days of the contract, we pay out-of-network (OON) providers 100% of the Medicaid FFS rates to support continuity of care. We allow members to continue treatment with any prescribed medications for a minimum of 90 calendar days and ensure provision of a 72-hour emergency supply of prescribed medication as needed. Additionally, we have established SFTP data exchange capabilities to transfer authorizations and Care Management information such as care plans, to ensure a seamless transition experience and non-disruption of member services and provider administrative functions. **Table 112.A.** outlines key activities of our approach to member transitions.

Table 112.A. Continuity of Care Key Tenets

Entity	Continuity of Care Key Activity
From another MCO	• Direct Coordination with other MCOs to obtain information on existing authorizations and care plans. • Extract data from CyncHealth to obtain diagnosis and current provider information about the member historical and existing services • Closely monitoring pharmacy and claims information during the first 90 days to identify medically complex members to ensure effective continuity of care. • Coordinating with MCNA to obtain dental information on existing authorizations, care plans, and providers for incoming members.
From FFS	• Extract data from CyncHealth and the State's pharmacy benefits manager (PBM) to obtain diagnosis, prescription, and current provider information about member historical and existing services. • Coordinating with MLTC to obtain needed information including medical, behavioral, pharmacy, and dental service authorizations and claims. • Closely monitoring pharmacy and claims information during the first 90 days to identify medically complex members to ensure effective continuity of care. • Coordinating with MCNA to obtain dental information on existing authorizations, care plans, and providers for incoming members.
Provider Level for All Transitions	• Coordinate with providers involved with the member care to obtain information about existing services, including Home and Community-Based Services (HCBS) coordinators for members with waiver services. • Automatic administrative authorization, continuation of services and claims payment for participating and non-participating providers, when enrolled with Nebraska Medicaid. • Transitioning members seamlessly into our plan through outreach, assessments, new plan of care development, and ensuring members have a medical home, dental home, and a BH home, as applicable.

Designated Transition of Care Coordinator. Due to the complexity of transitioning members into, out of, or between health plans, especially for members with complex conditions and persons with disabilities, we have designated a Transition of Care (TOC) Coordinator. This position serves as a single point of contact to promote and streamline communication between entities during transitions of care in or out of our health plan. They collect and document relevant member-specific information into TruCare Cloud, our collaborative Service Coordination and Utilization Management platform. This enables us to share it with providers, Care Management, community stakeholders, and another MCO as needed, facilitating continuity and coordination of care. ***In 2021, we successfully transitioned 403 members from another MCO to Nebraska Total Care.*** To promote coordination and seamless transition, we have established relationships and designated points of contact with each Heritage Health MCO and MCNA.

As we learn information about a member's transition in or out of our plan, our TOC Coordinator collaborates with the member, their Primary Care Provider (PCP), BH provider(s) and Dental Home provider if applicable, and any treating specialists or ancillary providers, LTSS case managers, and community agencies to coordinate transition of care activities. All member health information is shared in accordance with HIPAA, State and Federal privacy practices, and scope of work and contract requirements. ***We ensure seamless member care by improving communication among other entities serving the member.*** We actively communicate with stakeholders (members, providers, agencies, and community stakeholders) during member transition into our plan. By emphasizing communication and collaboration with these partners, we promote MLTC goals for an administratively efficient and member-centric process. Via our secure Community Partner Portal, we identify and exchange PH, BH, dental health, pharmacy, and Social Determinants of Health (SDOH) information and resources on a real-time basis for members transitioning between entities. We honor requests to maintain relationships with existing providers, including specialists, during the initial 180 days of the contract. During the initial 180-day period and for the duration of any prior authorized service, out of network providers will be reimbursed at 100% of Medicaid FFS rates.

Priority Outreach to Vulnerable Populations. We recognize continuity of care is particularly important for members with medically complex conditions, with a critical point in their plan of care, with a disability, or for members who are part of the Aged, Blind and Disabled (ABD), Foster Care, or Katie Beckett waiver populations. To ensure we meet these members' needs, we coordinate across the care continuum to minimize any disruptions in services, preserve established member/provider relationships, and ensure the member is well informed and comfortable with the transition as it occurs. While all newly transitioned members receive outreach within 90 days of enrollment, our staff prioritize outreach to new members who are at highest risk to ensure there is no disruption in services during the transition. These prioritized members include those:

- Hospitalized at the time of enrollment
- In out of home placement
- Requiring post-discharge follow-up and therapies after transition or out-of-area specialty services
- With prior authorization for scheduled surgeries, including dental procedures
- With complex conditions or treatments such as enteral feedings, oxygen, wound care, ventilators, or chemotherapy and/or radiation therapy
- With significant medical conditions, such as:
  - High-risk pregnancy or pregnancy within the last 30 days
  - Need for organ or tissue transplantation
  - Chronic illness resulting in hospitalization
- With conditions requiring ongoing monitoring or screening, such as elevated blood lead levels
- With multiple providers
- Meeting criteria or are referred for, or request, Case or Chronic Care Management
- Receiving multiple medications
- Receiving medical supplies
- Changing to a participating PCP

Successful Transition from Another MCO

We approach each member transition according to the specific member's situation and care needs. Our approach to ensure continuity of care for members transitioning from another MCO includes:

- Community partner education prior to go-live (members, providers, and community organizations)
- Identification of the member via MLTC eligibility file
- Identification of existing services utilizing established interoperability data exchange
- Communication with previous MCO and MCNA to obtain information about the member's services and needs

- Communication with providers to obtain information on current treatment needs and authorizations
- Communication with HCBS service coordinators when members transfer from a waiver program
- Coordination of a transition of care plan
- Completion of a comprehensive health risk screening/assessment to develop a member-focused plan of care as needed
- Facilitation of continuity of care including service authorizations and out-of-network (OON) services that may be in place by honoring existing authorizations from the prior MCO during the transfer of care period.

Stakeholder Education Before Go-Live. Educating stakeholders about expectations during the transition process ensures members have a seamless transition into our plan. This holistic approach ensures that members and providers are focused on the member's care rather than administrative procedures. Sharing information with incoming members about the process and whom they may contact if they have questions or concerns creates ownership and establishes the first level of trust with the member. Conducting webinars and in-person educational sessions with providers and community stakeholders equips these trusted member sources with information and resources needed to direct or assist the member should they have concerns regarding their transition to our plan.

Member Education. We educate current and new members about the transition process, including continuity of care, through the Member Handbook, new member welcome materials, welcome calls, and new member journey emails, text messaging, our website, Member Portal, and through interaction with Care Managers.

Provider Education. For at least 30 days prior to go-live, our Provider Relations Representatives conduct a series of town hall meetings to inform providers about transition processes and stress the importance of notifying us when a member requires transition support. Information about the transition process is shared through our Provider Portal, Provider Handbook, Provider Billing Guide, public website, and Care Management and Provider Relations staff. Each of our contracted providers, medical, dental, and BH, have an assigned Provider Relations Representative (PR) to facilitate swift and effective resolution of any transition concerns. Our PR staff conduct a series of weekly webinars for at least 30 days post go-live to identify and resolve common concerns, share lessons learned, and rapidly identify solutions for new issues. During these sessions, providers are also educated on how to request service authorization extensions, if needed. Education is open to contracted providers, OON providers and key stakeholders.

Community Partner Education. At least 30 days prior to go-live and for 30 days post go-live, webinars and in-person educational sessions are conducted with community agencies such as, and not limited to the Nebraska Association of Behavioral Health Organizations, Physical Therapy / Occupational Therapy / Speech-Language Therapy Associations, Home Health Association, Nebraska Dental Association, Nebraska Hospital Association, Nebraska Medical Association, Healthcare Association of Nebraska, Nebraska Health Departments, American Association of Healthcare Administrative Management and the Rural Health Association. The events equip community and faith-based organizations with an overview of MLTC's enrollment process, the steps we take to ensure continuity of care for members, how to reach us after go-live, and actions that members or their advocates can take if they have transition concerns.

Identifying Existing Services. We employ a variety of methodologies, such as interoperability data transactions, to identify new members requiring transition of services, including:

- ***Historical claims information extracted from CyncHealth.*** We are an active participant in the State's HIE, CyncHealth. We routinely pull member information from CyncHealth and incorporate any new data, such as hospital stays, labs, pharmacy information, and PCP and specialist visits with diagnosis codes, that have not yet been received by our claims system.
- ***Open authorizations, care plans and historical claims from MCO.*** Data received is loaded into our TruCare Cloud to identify members for Care Management as well as existing services and medical, behavioral and dental conditions for incoming members
- Health Risk Screening conducted within 90 days of a member enrolling
- Incoming provider communication for service authorizations and Care Management referrals
- MCNA scheduled dental services, open authorizations, and care plans
- Pharmacy data

Coordination with Prior MCO. Our TOC Coordinator outreaches to the previous MCO to ensure a smooth transition to Nebraska Total Care. We request key information, including:

- Service history, including recent utilization (such as hospitalizations, substance use treatment)
- Diagnoses for physical, behavioral, and dental health
- Current PCP, and Dental Home including input received from the PCP, Primary Dentists, and other treating providers
- Provider treatment plans

- Results of any recent Care Management assessments and the current plan of care including medications, member goals, and preferences
- Pregnancy status, if applicable, OB/GYN and member's planned hospital for delivery
- Current contact information and emergency numbers for member, caregivers, and any authorized designee
- Other information on the member's needs and barriers to care
- Administrative information such as previously filed/pending grievances and appeals and any provider issues
- Copies of member's Durable Health Care Power of Attorney, Advanced Directives, and other such documents

Coordination with Providers. When our plan receives the eligibility file for a transferred member, the transferring MCO name is noted in our eligibility system record, and all member-related data, such as claims and current plan of care received from the transferring MCO, is uploaded and stored in the applicable member dataset. Our system honors the member's PCP relationship by assigning the same PCP and Nebraska Total Care notifies the PCP of the member's effective date with our health plan. Upon reviewing member information from the prior MCO, for those members previously in Care Management with the transferring MCO or identified as having Care Management needs, our Care Management Team coordinates with the member and their providers to develop an updated plan of care. We work closely with providers to ensure they understand the type, scope, and duration of the previously authorized services and the need to ensure continuity of care.

Coordination with MCNA. We have effectively coordinated with MCNA in the past to administratively simplify the dental anesthesia authorization processes for approved services. We established a collaborative relationship with MCNA over the last several years, including quarterly meetings to discuss referrals and Care Management for our members with dental needs. We will build upon this relationship to ensure continuity of care information is effectively transferred during the transition of dental services to Nebraska Total Care. We will request historical claims, scheduled services, open service authorizations, open Care Management cases and other relevant information, member's dental home, and other plan of care details. As noted in the provider network section of our response, we intend to contract with as many MCNA dental providers as possible to further aide in the continuity of care for transitioned and existing members.

Continuity of Existing Services and Authorizations. Authorizations requests received from OON providers are administratively approved and honored for any new members transitioned from another MCO or FFS during the initial 180 calendar days of the contract. This allows claims to auto-adjudicate, ensures providers are paid on a timely basis, and facilitates continuity of care for the member. We connect OON providers to our Provider Relations and Network Contracting departments. Provider Relations staff educate these providers on authorization processes after the 180-day transition period. If a member needs to access the OON provider's services beyond 180 days, our Contracting Team proactively outreaches to contract with that provider. If the provider chooses not to contract with us, we utilize OON benefits or explore single case agreements with the provider as warranted.

Member Engagement in Development of a New Plan of Care. For members with existing Care Management or ongoing service needs, our Care Managers first provide service information, emergency telephone numbers, and instructions on how to obtain additional services for members impacted by a transition. Our Care Managers then complete a comprehensive assessment and develop a new plan of care in conjunction with the member, caregiver, existing network, and non-contracted providers, including the PCP, BH providers, specialists, or other providers, including in-home supportive services providers, and any Care Manager from the previous MCO, to identify and address the member's medical, BH, dental, social needs, supportive services, SDOH gaps, and other needs as identified.

For members who are hospitalized at the time of enrollment, our Transition of Care Coordinator contacts the member in the hospital to discuss their care and enrollment into our plan and coordinates the discharge planning process with the member and outpatient/home care providers, as applicable. The Transition of Care Coordinator facilitates a warm transfer to a primary Care Manager that initiates the follow-up contact with the member to ensure the member agrees with the new plan of care and that all services are initiated according to the plan and are meeting the member's needs; forwards the new plan to the member's PCP; and documents it in TruCare Cloud.

Successful Transition from Fee-for-Service

Our approach and processes for successfully transitioning members from FFS mirror the processes used when a member transfers from another MCO. As noted above, our approach for ensuring continuity of care for members transitioning from FFS includes:

- Community partner education prior to go-live (members, providers, and community organizations)
- Identification of the member via the MLTC eligibility file
- Identification of existing services via various claims sources and coordination with MLTC Care Managers

- Outreach to member's providers for information on current treatment, existing authorizations, and needs, as indicated
- Coordination of a transition of care plan, if needed
- Completion of a comprehensive assessment and development of a new plan of care for members with an existing plan of care, or with medically complex or ongoing needs
- Facilitation of continuity of care including service authorizations and OON services

Processes and procedures described in the Successful Transition from Another MCO section are implemented in the FFS transition process. We coordinate with MLTC and the State Pharmacy Benefit Manager (PBM) to gather information on the member's specific needs and educate members that are new to managed care.

Coordination with MLTC and the State PBM. To successfully transition FFS members into managed care, we work closely with MLTC to obtain detailed claims and authorization information. In combination with the other sources noted in the MCO Transition section above, we use this information to identify existing services accessed by the member, current treating providers, and member health conditions. We work closely with the State's PBM to collect information on current prescriptions and authorizations to ensure there is no disruption in a member's access to prescribed medications. We pay particular attention to identifying existing services and providers for the ABD, Katie Beckett waiver, and Foster Care populations for whom stability with existing providers and services without disruption is especially important. While all newly transitioned members receive outreach within the first 90 days of enrollment, ***our staff prioritizes outreach to new FFS members who are at the highest risk levels, to ensure there is no disruption in services during the transition.*** We follow the same protocols identified for members transitioning from another MCO.

Educating Members New to Managed Care. We ensure a smooth transition for members that are new to managed care with minimal disruptions to ongoing services, provider relationships, and existing supports. We educate members who are new to managed care about the transition process through our Care Managers and new member materials including the Member Handbook, Member Portal, the new member call, and our new member journey email communications that are sent in intervals to support new members at key points in their onboarding as a Nebraska Total Care member. ***The information provided emphasizes the importance of continuing existing services to prevent unnecessary gaps in care,*** the time frame for honoring their pre-existing service authorizations, and the process for obtaining authorization for the continuation of medically necessary services. Education will include information about value-added services the member would not have previously had access to. New in 2023, all members will be offered an in-home visit or visit within their community.

For members enrolled in Care Management, we recognize family members play a key role in successful transitions. Our Care Managers create mechanisms to encourage the member's families, advocates, caregivers, and other natural supports and community affiliations to be actively involved in the member's person-centered planning process, including assessment, individual plan of care development, accessing needed services, and evaluating services received.

We work closely with community stakeholder organizations and State agencies, such as ***Assisted Technology Partnership, Area Agencies on Aging, Lincoln Homeless Coalition, Caregivers Coalition, and Olmstead Advisory Committee and Housing Workgroup***, to explain the shift to managed care and ease the transition for members accessing these services. For the IDD population, ***we implemented an innovative approach with a designated multi-specialty team of coordinators trained to support the unique needs of these communities.*** As an example, we have a designated Community and Disabilities Liaison to assist providers in providing care as well as identifying, accessing, and receiving key resources for this population.

RFP 112209 O3

B. Technical Approach

V.Z Electronic Visit Verification for Home Health Care Services

V.Z Electronic Visit Verification for Home Health Care Services

113. The Bidder must attest they understand the obligation to work with the other awarded MCOs to procure a common EVV vendor and the associated work outlined in this section. ***Page Limit: 1***

Nebraska Total Care affirms our understanding of our obligation to work with other awarded MCOs to procure and collectively contract with a common Electronic Visit Verification (EVV) vendor for Home Health Care Services (HHCS). We affirm our understanding of the associated work outlined in Section Z. of the Scope of Work, including the general, functional, CMS certification, quality management, performance monitoring, training, reporting, data, and implementation requirements.

Experienced Partner Ready to Procure, Implement, and Operate an EVV Program for Nebraska

Through the Nebraska Managed Care Organization (MCO) Association, of which our CEO Heath Phillips is the current President, we have collaborated with other MCOs and MLTC, on the successful implementation of the Enhanced Ambulatory Patient Groups (EAPG) reimbursement methodology. We are backed by the expertise of our parent company, Centene, and our 17-affiliate Medicaid managed care programs that manage EVV systems for Home and Community-Based Services (HCBS), Long Term Services and Supports (LTSS), and home health care services for traditional Medicaid populations. Our enterprise experience includes ten successful implementations over the past three years. Through our parent company and affiliates, we bring experience with various contractual arrangements, including EVV systems selected by the state and those we contract with directly. Our affiliates in Iowa, Pennsylvania, and New Mexico successfully collaborated with other MCOs to procure a common EVV vendor for their respective states. Nationally, we have become a leader within these states, presenting best practices and recommendations regarding EVV systems to state partners such as Iowa, New Mexico, New Jersey, and New Hampshire. See **Table 113_Experience Implementing and Managing EVV Systems**.

Table 113 Experience Implementing and Managing EVV Systems

State	Year Implemented	Current EVV System Vendor
New York	2022	HHA Exchange
North Carolina (2 Plans)	2021	HHA Exchange
Arkansas	2020	HHA Exchange
Arizona (2 Plans)	2020	Sandata
Hawaii	2020	Sandata
Iowa	2020	CareBridge
New Jersey	2020	HHA Exchange
Wisconsin	2020	Sandata
Nevada	2019	FISERV/First Data
Ohio	2019	Sandata
Florida	2018	HHA Exchange
New Mexico	2018	FISERV/First Data
Pennsylvania	2018	HHA Exchange
Texas	2018	TMHP/Accenture
Kansas	2014	FISERV/First Data

MIS Ready to Integrate with an EVV Solution Provider. Since 2013, our Management Information System (MIS) has exchanged data with various EVV systems and aggregators across our affiliates. Our MIS supports the use of any EVV system that adheres to HIPAA-based standards for transaction formats and complies with Federal and State standards for security, data integrity controls, claims matching, and audit transparency. We can accept electronic claims from an EVV system at any frequency, including daily.

RFP 112209 O3

B. Technical Approach

Additional Innovations

Additional Innovations

114. Describe any additional innovations the Bidder to will employ to help improve health outcomes. The following is an example outline of information to submit for each innovation.
1. General Overview
• The innovation name with a detailed description, highlighting the functions, specifications, and outputs.
• A description of how the proposed innovation functions in a planned operational setting, including evidence, measured, quantified, or observed data that demonstrate the specifications of the proposed innovation were achieved.
• The expected life cycle, in years, of the proposed innovation for the end user.

2. Features and Benefits
• Describe the features and benefits of the proposed innovation, including any relevant qualitative or quantitative data or measurable benefits.

3. Intellectual Property (IP) Rights and Ownership
• Indicate the patent status and patent ownership status relating to the proposed innovation.
Page Limit: Not applicable

Providing Innovative Solutions to Help Improve Health Outcomes

To fulfill our vision to transform the health of the community, one person at a time, Nebraska Total Care has worked alongside MLTC since 2017, providing comprehensive managed care services to Heritage Health members across Nebraska. As a locally based, quality-driven organization, Nebraska Total Care brings a deep understanding of the unique needs and preferences of Nebraska Medicaid populations, their families, and the providers and community-based organizations (CBOs) that work with us to serve them.

Innovation is the foundation of what we do to help improve health outcomes. Applying clinical, public health, and analytics best practices, we identify local needs including Social Determinants of Health (SDOH) and disparities and develop innovative, community- and provider-anchored solutions designed to serve our diverse membership and the urban, rural, and frontier communities across the State.

Throughout our entire RFP response, we describe many current and planned innovative programs, solutions and initiatives designed to meet local needs, as summarized in **Figure 114.E** at the end of this response to Question 114. Here, we describe in greater detail ***four targeted strategic innovations*** that Nebraska Total Care will offer to improve members' access to services, optimize members' health outcomes, and advance health equity.

- **Innovation #1: Our Rural Health Model and Project Access Initiative** that includes a strategic partnership program with the Health Center Association of Nebraska (HCAN) to increase access for physical health (PH), BH and dental services.
- **Innovation #2: Health Equity Model** that consists of the development and implementation of Health Equity Improvement Neighborhoods
- **Innovation #3: Increasing Access to Dental Care Model** that includes an array of programs and initiatives to ensure access to dental services and promote dental health
- **Innovation #4: Strong Start Model of Care** for justice-involved populations that consist of our Reach-In and Re-Entry Programs, Virtual PCP, and our Housing First Model

Innovation # 1: Rural Health Model and Project Access

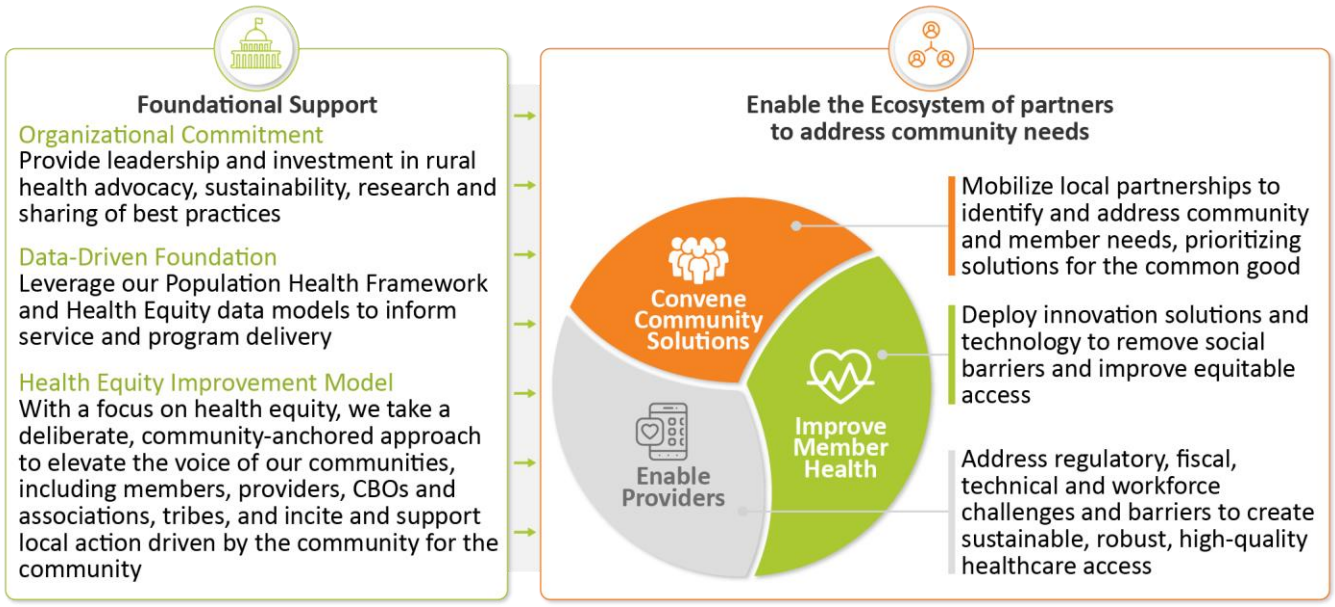
1. General Overview

Rural Health Approach

Nebraska Total Care has a long history of working with rural and frontier community and provider partners, including Federally Qualified Health Centers (FQHCs) and Critical Access Hospitals, to develop and implement sustainable rural health solutions that leverage existing resources and programs to bring needed services to members. Eighty-five percent of the State (79 out of 93 counties) is considered rural or frontier, with 41 identified provider shortage areas. Further, approximately 21 percent of our members enrolled in Nebraska Total Care live in a rural or frontier community. We are committed to helping bring a collective focus to issues facing rural and frontier communities across the State and to working collectively to design and implement innovative programs that will improve the health of the community.

A Diverse Response to a Diverse Need. Rural health needs are diverse, driven by racial/ethnic diversity, varied cultural and behavioral influences, geographic diversity, disparities in outcomes and the availability of health and social resources, and differences in technology access and social needs. The definition of rural goes beyond rural versus urban, but includes frontier areas, tribal reservations, and other unique communities. Some of the unique characteristics found among individuals living in rural areas include a greater emphasis on independence and self-reliance, a tendency towards self-abnegation, and concerns about confidentiality and community gossip. Rural populations are also known to be medically underserved, with high health disparities, and exacerbated social needs. For all these reasons, our approach to improving health outcomes in rural communities is not a single solution, but a tailored set of solutions driven by the community, for the community.

Figure 114.A: Community-Anchored Rural Health Approach



Innovative Solutions and Partnerships. Built on an organizational commitment to rural health, we leverage our population health and health equity framework and analytics to engage with communities, solicit input on how best to communicate and promote access, and jointly develop interventions to address barriers to care and optimal health outcomes. Those who live and work in the communities we serve, especially rural and frontier communities, have the greatest understanding of the inequities, challenges, key strengths, and local resources and infrastructure that exist and can form the foundational elements of local solutions. Our approach, therefore, begins with ***listening to and empowering local voices***.

We build strong relationships via personalized outreach, education, and support, engaging and earning the trust of both providers and members. Consistent with our ***foundational support pillars*** described in **Figure 114.A** above, Nebraska Total Care is investing in rural health solutions that include a strategic partnership with HCAN and its network of FQHCs and an array of innovative, community-anchored initiatives and solutions to increase access to services, including in rural and frontier areas of the State.

"…I have been very impressed with the relational focus Nebraska Total Care has been able to keep with the Medicaid Members and Providers they serve… I have experienced the benefit of their person-centered focus in my position as CEO of a rural mental health... I would describe Nebraska Total Care as a managed care company that encourages innovation and excellence in mental health/substance abuse services through authentic, caring relationship. They have served those suffering with mental health/substance abuse disorders well and I hope they will be given the chance to continue being a part of managing Nebraska's Medicaid services in the future.

- Dr. Mark E. Stortvedt, Ph.D., LIMHP, CPC, Executive Director, Oasis Counseling International

Expected Lifecyle. The expected lifecycle of the program is the term of the new Heritage Health Medicaid managed care contract period.

2. Features and Benefits

Rural Health Model

Highlighted below are examples of innovative models and approaches we are deploying as part of our Rural Health Model, which include ***Project Access, Telehealth Solutions, and Building Provider Capacity through Trainings.***

Project Access: Health Center Association of Nebraska and Nebraska Total Care Partnership. FQHCs are at the center of providing high quality, affordable health care to Nebraska's underserved populations in urban, rural and frontier communities across the State. Increasing patient/member access has become a shared primary goal for HCAN, HCAN members, MLTC, and Medicaid Managed Care Organizations (MCOs) in the State, including Nebraska Total Care. The ability for FQHCs to create additional capacity to ensure access to services, including in rural and frontier areas of the State, however, is limited by a couple of factors.

We know from our listening sessions with HCAN and their FQHC members and community stakeholders, there is a shortage of providers, and FQHCs have difficulty recruiting providers, particularly in rural and frontier areas of the State. For example, currently in Nebraska, 13 of 93 counties have no primary care physicians, 44 counties have no OB/GYN physicians, and 78 counties have no practicing psychiatrists. Additionally, Administrators of FQHCs have identified an inability to recruit primary care, BH, and dental providers as the primary limiting factor for increasing access. FQHCs are also losing potential candidates due to pay discrepancies and upfront incentives offered by private practices.

Secondly, the inherent operational challenges that come with serving a mostly low-income population base is also contributing to access challenges. Many FQHC patients struggle with SDOH barriers, such as lack of reliable transportation and work hourly jobs that make it more difficult to make appointments. This can lead to increased no-show rates and a lack of efficiencies within clinic operations. In many rural and frontier Nebraska communities, FQHCs are also the only provider actively accepting Medicaid members, leaving few options for members to seek care. This results in delays in preventive care and early interventions. Members are often left to seek care from emergency departments in lieu of a more appropriate level of care but still have limited options for follow-up care.

In direct response to these challenges, Nebraska Total Care, will support Project Access with initial seed money of $1 Million from Centene Foundation. We will continue to invest in Project Access in subsequent years, and will ***partner with HCAN to establish Project Access to focus on increasing patient access in FQHCs through more competitive compensation, improved clinic operations, and increased capacity.*** Project Access consists of the following four main components.

- **Component 1-Establishment of a Recruitment Assistance Fund.** A recruitment fund will be established to assist FQHCs in offering more competitive compensation packages through supporting upfront incentives such as sign-on bonuses, loan forgiveness, continuing education, licensure expenses and/or relocation assistance. This fund will be administered by HCAN for the explicit use of recruiting PH, BH, and dental providers, including hygienists. HCAN, with guidance from a steering committee, would be responsible for establishing the processes for evaluating requests from and distributing funds to FQHCs. The recruitment fund will be structured to retain providers who are recruited. For example, any distributions to providers will require a minimum commitment from MD/DO level providers of 1 year per $50,000 and non-MD/DOs of 3 years per $50,000.
- **Component 2-Clinic Optimization Funds to Enhance Patient Access.** FQHCs will be encouraged to review their operational processes for patient scheduling and throughput. Project Access will make funds available for clinical optimization based on FQHCs requesting and projects being approved. FQHCs will be able to request funds based on

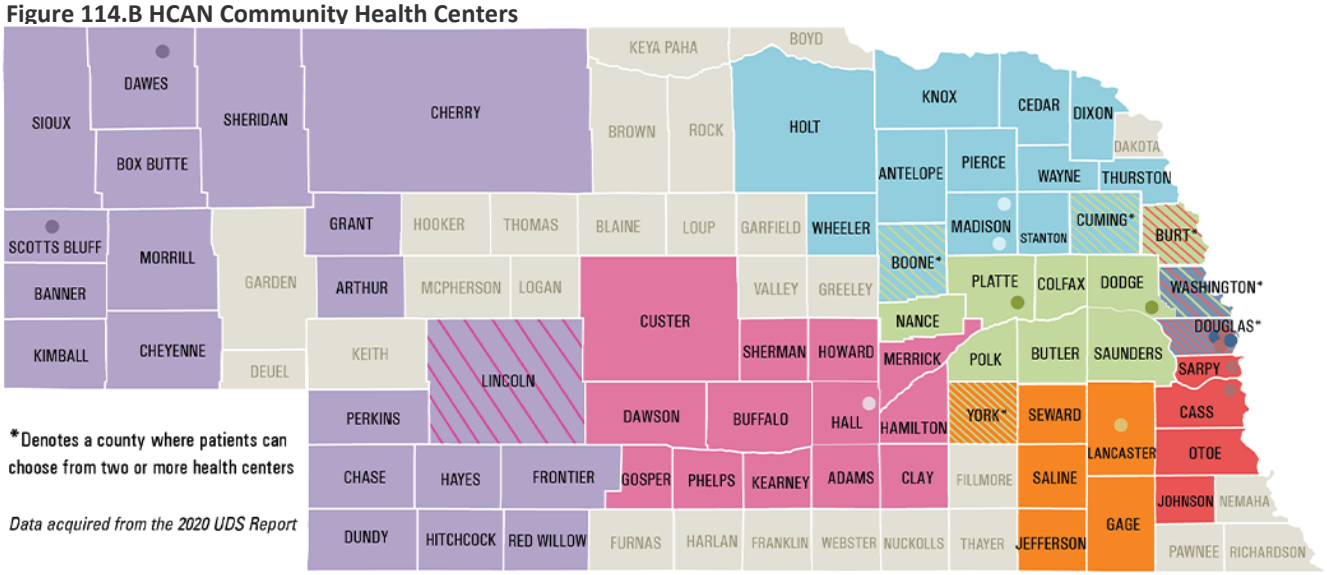
potential impact to enhancing patient access. This could include, among other things, hiring consultants or upgrading technology. HCAN and the project steering committee will establish criteria for submission and evaluation of all efficiency improvement requests. Priority will be given to projects that emphasize improvement in scheduling practices to reduce no-shows and increase same/next day appointments.

- **Component 3-Increasing Capacity to Serve Underserved Populations:** Investment in programmatic development that will increase access through "meeting members where they are" and adding physical capacity to serve underserved populations. This could include increasing capacity at an existing location, expanding telehealth capabilities, development of mobile programs (such as a dental van), and/or advancement of de novo projects. As a part of Project Access and with input from the steering committee, HCAN, will develop a capital request process to include a description of the projected number of increased patients seen as a result of a proposed project. FQHCs will also be required to provide proof of the project's financial viability, operational plan, and timeline.
- **Component 4- Workforce Development Initiatives**: As Project Access matures, ensuring a pipeline for future health care workers will be essential. Like most of the country, Nebraska is experiencing a health care worker crisis that is only projected to worsen in coming years. For instance, according to the Nebraska Center for Nursing, Nebraska will experience a workforce shortage of 5,435 nurses by 2025. There aren't enough nurses, technologists, therapists, or dental hygienists to account for future patient need, particularly in rural and frontier settings. When health care shortages exist, it often impacts underserved, less financially stable populations. If there is not a solution in place to grow the number of students graduating in health sciences and choosing to stay in Nebraska, it will be extremely difficult to sustain program gains. Over time, it will be a goal of Project Access to create a think tank of community stakeholders to evaluate factors limiting the output of more health care workers and how to attract those employees to FQHCs. The steering committee will seek out additional community stakeholders in the education system, such as the Nebraska Community College Association, and health care fields to examine the following:
  - Health care related programs and technical school offerings in high schools
  - Degrees and certificate programs and capacity in Nebraska Community Colleges
  - Availability of Associate Degree programs in rural Nebraska
  - Clinical rotation opportunities in FQHCs
  - Scholarship programs for commitment to work in a Nebraska FQHC
  - Pay discrepancies and opportunities for creative compensation structures

Upon the steering committee's review and contingent on available funding, Project Access may choose to make financial investments that directly contribute to increasing the pool of health science graduates in the State of Nebraska with an emphasis on programs with clinical affiliations with HCAN members.

Geographic Coverage. Through our strategic partnership with HCAN, we are able to offer our innovative ***Project Access*** program on a statewide basis. Highlighted in the map below are locations of HCAN Community Health Centers that will be a part of Project Access.

Figure 114.B HCAN Community Health Centers



Note: Shaded colors represent HCAN community health center service areas

"Since the inception of Heritage Health, Health Center Association of Nebraska (HCAN) and Nebraska Total Care have maintained a collaborative partnership focused on enhancing and expanding access to care for Nebraska's underserved populations. Whether it is working together to address administrative questions to supporting outreach efforts in Nebraska's Federally Qualified Health Centers (FQHCs), Nebraska Total Care has always maintained an open, cooperative relationship with us. Our current work on Project Access will profoundly change the ability of Nebraska's FQHCs to expand access to medical, dental, and behavioral health services; ensure the recruitment and retention of a mission-driven workforce; and stabilize access to care in rural and underserved communities across the State. Nebraska Total Care understands the unique needs of Nebraska and works closely with community partners to address barriers to accessing health care. We are grateful for our long-standing partnership and look forward to expanding our mutual work in the future."

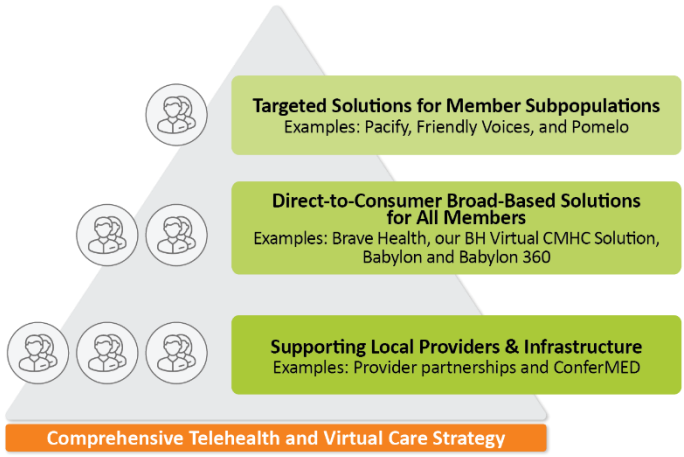
- Amy Behnke, J.D., CEO, HCAN

Telehealth Innovations. In addition to Project Access, Nebraska Total Care is also investing in telehealth and virtual care solutions as a key strategy to bring greater health care access to rural and frontier communities in the State. These innovative solutions are designed to build provider capacity, increase access to diverse and high-quality specialists, improve integrated management, and improve member and provider satisfaction.

Nebraska Total Care's telehealth and virtual care strategy takes a multi-pronged approach **(see Figure 114.B)**, focusing first on expanding local provider's telehealth capacity while offering wrap-around broad-based and targeted telehealth solutions to further enhance health access and outcomes. Through data collection and analysis, Nebraska Total Care understands that our members have varying familiarity with telehealth and differing health needs for which they seek telehealth solutions, and providers have varying needs to effectively extend their practices via telehealth. Nebraska Total Care aims to ensure that all our members have access to appropriate telehealth offerings, while maintaining and expanding the essential role of networked PCPs. Nebraska Total Care also supports additional virtual care solutions such as eConsults and virtual provider-to-provider education, specialist consultation, and BH referrals to increase capacity and access to care in Nebraska. We will also promote the availability of telehealth through member outreach and education and our boots on the ground staff on how to access services.

Our innovative telehealth solutions, described below, provide: ***Targeted Solutions for Member Subpopulations; Direct-to-Consumer Broad-Based Solutions for Members, and Local Provider Supports and Infrastructure***.

Targeted Solutions for Member Subpopulations. We will offer the following innovative solutions to address the unique needs of our members, such as members with behavioral health needs and members experiencing social isolation.



- **Friendly Voices.** To address social isolation, we will offer Friendly Voices, an innovative volunteer-based program. Nebraska Total Care will be using our predictive model to identify members who are identified as at risk for social isolation or loneliness. Through outreach from our Care Managers, Nebraska Total Care will confirm social isolation or loneliness and prioritize members for the Friendly Voices program with the highest scores. The Friendly Voices program links local community-based volunteers that can facilitate ongoing calls with members facing social isolation who would like more social contact, creating meaningful connections across the community. This solution makes meaningful connections and allows for tailored calls to be made to our members.
- **Medication-Assisted Treatment (MAT).** Members in rural and frontier areas of the State who are living with or at-risk for OUD need access to comprehensive and compassionate integrated care across the full continuum of prevention, treatment, and recovery. Telehealth-supported MAT is a viable mechanism to expand access to MAT services in rural and frontier areas of the State where there are no available SUD treatment providers.
- **Virtual Doula Services.** Traditionally, doula services are carried out in person, with doulas attending doctor appointments, assisting during the birth, and visiting mom and baby afterward at home. However, there is a growing

number of doulas now offering their services virtually via video sessions and texting, giving them the ability to support families regardless of location, time, or hospital restrictions. The ***Pacify*** program offers expecting and new mothers unlimited 24/7 video access to certified doulas, dieticians, and lactation consultants. Pacify has shown a 26% decrease in non-emergent ED visits by reaching new parents in their moment of crisis, and an increase of up to 23% in breastfeeding rates. Our Virtual Doula Services program will offer members the option of virtual visits by a doula for prenatal, labor and delivery, and postpartum support, including lactation consultation.

In addition to above targeted solutions, through our MOVES Mobile Solutions, we will bring care directly to rural and frontier members. Mobile solutions deployed or being deployed in Nebraska include:

- **Mobile Vans.** Through mobile clinics, we bring primary care to rural members. Our vans, equipped to offer, Dental and Vision Screening and Services, etc., are located at fairs, community events, disaster relief sites, and community shelters.
- **Member Connect Stations**. Kiosk tablets located at FQHCs and community sites, such as shelters, for members to access resources, for example, SNAP/WIC enrollment, telehealth, and complete screenings and assessments, such as Notification of Pregnancy Forms to facilitate timely access to prenatal care services.
- **ConnectionsPlus Program.** Members receive support with cell phone and connectivity to support access to telehealth solutions through our ConnectionsPlus program.
- **BH on Board.** This program enables on-demand telehealth access to BH services for crisis stabilization and therapy by equipping first responders with cellular-enabled tablets and a virtual visit platform. First responders have access to 24/7 BH and SDOH telehealth crisis services to reduce ED and inpatient admission and unnecessary involvement with law enforcement due to a BH crisis.

Direct-to-Consumer Broad-Based Solutions for Members. We recognize that members in rural and frontier areas often struggle with access to primary care and specialty services due to both the scarcity of services as well as long travel time. Our statewide telehealth solution provides members with access to virtual visits and enhances member engagement to improve quality of care, increase health literacy, and promote health equity.

- **Babylon Virtual Care Platform.** Nebraska Total Care will partner with Babylon Health to offer all members access to physical and behavioral health virtual care visits seven days a week. Through our partnership with Babylon, Nebraska Total Care provides unparalleled access to care for pediatric and adult urgent care needs. Babylon's platform utilizes leading edge digital technology and artificial intelligence symptom-checking tools to first triage members and determine the correct point of care. Based on their symptoms and concerns, members are then connected with a provider for a visit, from which they may be given a diagnosis and treatment plan, as well as medications as necessary. Through Babylon's mobile application, members also can utilize self-guided risk assessment and health management tools, including Babylon's "digital twin" functionality, where members can input their known health data, and better understand possible long-term health risks for example, heart disease to take proactive preventative measures to reduce those risks. Further, members can also utilize the Babylon mobile application to set medication and symptom tracking reminders, helping them be actively engaged in their health. At the end of every telehealth visit, members may provide a star rating for their consultation and provide feedback, to help Babylon and Nebraska Total Care continuously improve the member's virtual visit experience.
  Babylon 360. Through Our ***Babylon Integrated Care Platform (Babylon 360)*** model of care, we can identify a cohort of members with low primary care utilization and support them via telehealth PCP services. Our Care Management team and Babylon's Care Advisor co-manage the member's care by providing Care Coordination, member education on available benefits, community resources, and Care Management programs. Babylon 360 augments access to care for members living in Nebraska and removes barriers to care, for example, transportation, childcare, prescription management, and preventative care. It also simplifies accessibility for members with disabilities or limited English proficiency. Supporting whole person care, Babylon 360 assesses and connects members to SDOH resources in partnership with Nebraska Total Care's care management team. When a member needs to see a clinician virtually, ***Babylon 360*** displays the earliest available appointment times, or the times closest to a member's preferred time. A two-way video and/or audio consultation is then available for the member to select and book for a visit direct to the member's mobile phone or home. At the end of every telehealth visit, the member may provide a star rating for their consultation and provide feedback on their experience. For services requiring an in-person visit, for example, immunizations, Babylon utilizes Nebraska Total Care's contracted network of local providers for physical care when needed and appropriate and to help patients navigate through their entire health experience.
- **Virtual Community Mental Health Center.** We offer ***Brave Health***, a virtual Community Mental Health Center platform and model providing child, adolescent, and adult psychiatry, therapy, substance use disorder care, hospital transition support, medication adherence intervention, and health navigation engagement telehealth services. Health navigation

services are conducted through Brave Health's Psychiatric Navigation Program (PNP), which links members to a Navigator who conducts 1:1 check-ins and solution-focused brief therapy to ensure successful linkage with a psychiatric evaluation. Preliminary outcomes include a ***90% reduction in BH admissions and a 66% reduction in costs for individuals with a Brave Health encounter***. Brave Health's Psychiatric Engagement program has an 82% successful completion rate for child psychiatry evaluations, as compared to only 65% for children without PNP. Brave Health provides a value-based care resource model that focuses on 7- and 30- day follow-up visits after an inpatient admission to support HEDIS measure improvements and reduce inpatient readmissions

Supporting Local Providers and Infrastructure. Providers in rural and frontier areas need the right tools for success.

Telehealth is an increasingly important tool that can not only expand health care access in rural and frontier communities but can also support geographically isolated primary care providers (PCPs) by connecting them with opportunities for education and consultation. We will offer the following telehealth supports that enhance and support PCPs:

- **Financial support**: As described above, as part of our Project Access Initiative, we will offer FQHCs financial supports, funded through the plan as a one-time incentive or grant for Providers to adopt a telehealth solution or other supporting telehealth technology for their practice.
- **ConferMED Specialty eConsults:** We will support providers with ConferMED, an eConsult solution, which enables asynchronous, store-and-forward consults between PCPs and specialist providers to expand access, decrease service wait times, and reduce avoidable specialist visits, tests, and procedures. Historically, 80% of eConsultations result in a recommendation that avoids specialty care visits, supporting members in getting the care they need at the right time, without unnecessary visits. We will stage deployment and implement first where population health and access analyses demonstrate the greatest need. Nebraska Total Care utilizes eConsults to promote and support efforts that integrate primary care services within specialty BH settings as well as support primary care based BH for pediatric populations.

Building Provider Capacity through Trainings and a Supportive Learning Environment. Nebraska Total Care is committed to building provider capacity in rural and frontier areas of the State through trainings and shared learning environment in collaboration with our rural providers and partners. The collaboration will include training, consultation, and analysis and will help expand access to care in rural and frontier areas where specialty care is limited. We offer the following training programs and initiatives tailored to providers who practice in rural and frontier areas.

- **LifeBridge program.** We are partnering with LifeBridge to support providers in delivering care in Nebraska, by supporting the health and wellness of Nebraska physicians. The LifeBridge program provides peer coaches to help providers address the challenges of a medical career and receive coaching and supports to manage stress and address provider burnout.
- **Project ECHO**. We will connect local health care providers to medical specialists to bring their expertise and services to rural, frontier and underserved communities. Project ECHO enables providers to practice at the top of their license, acquire new skills and competencies (including increasing culturally competent and equitable care), and treat patients with common complex conditions rather than refer them on to a specialist. The collaboration will include training, consultation, and analysis and will help expand access to care where specialist care is limited.

Measurable Benefits

We will monitor outcomes and success of Project Access by monitoring, reporting, and evaluating the following outcomes for participating HCAN FQHCs:

- Patients seen year over year
- Providers successfully recruited to HCAN's FQHCs
- Overall capacity increased (scheduling slots) for physical, behavioral health and dental
- Improvement in FQHC no-show rates
- Additional services offered
- Number of students graduating from health sciences programs and accepting positions in FQHCs

3. Intellectual Property (IP) Rights and Ownership

There are no intellectual property rights or patent ownership relating to the above proposed set of innovative solutions and initiatives.

Innovation #2: Health Equity Neighborhoods

General Overview

Health Equity Improvement (HEI) Model

Health equity improvement is central to our purpose. We view health equity beyond just race, ethnicity, and gender. We embed health equity strategies within every facet of Nebraska Total Care's operations and programs. Our evidence-based, award-winning HEI Model, displayed in **Figure 114.C**, includes a four-step, data-driven process to develop, implement, and evaluate equity-focused interventions. This model aligns with MLTC's vision for reducing health inequities and our SDOH framework that focuses on eliminating disparities caused by social barriers to care.

The model uses integrated quantitative and qualitative data from multiple sources, including our Health Equity and SDOH Dashboards, focus groups, and key informant interviews to understand disparities. Our approach is centered on listening and leveraging the voices of our communities, providers, and members in the design and delivery of health services.

Figure 114.C Nebraska Total Care's HEI Model

Demonstrated Experience and Success. Using our HEI Model, Nebraska Total Care has successfully identified and mitigated disparities in Nebraska, such as

- Asthma medication - the disparity was reduced for Black members by 8.78% from 2019 to 2020.
- Follow-Up after Hospitalization - the disparity was reduced for Hispanic members by 6.14% from 2019 to 2020
- Antidepressant Medication Ratio - the disparity was reduced for Hispanic members by 4.76% from 2019 to 2020.
- Breast Cancer Screening - the disparity was reduced for Asian Pacific members by 5.42% from 2019 to 2020.
- Postpartum Care - the disparity was reduced for Black members by 3.06% from 2019 to 2020.

While we continue to demonstrate improvements, inequities persist. Building on the community-anchored, collaborative aspects of our HEI Model, we will design and implement ***new Health Equity (HE) Neighborhoods*** in high needs cities and zip codes across Nebraska. HE Neighborhoods is a Centene-developed national best practice for identifying and addressing disparities through hyper-focused community-wide engagement, learning from Robert Wood Johnson Foundation and other public health models.

Expected Lifecyle. The expected life cycle of the HE Neighborhoods is June 2022 through the term of the new Heritage Health Medicaid managed care contract period.

1. Features and Benefits

Features and Benefits of our Health Equity Neighborhoods

We start by engaging established, anchor community entities, such as local United Way and Urban League chapters, to conduct health equity formative research on local lived experience and needs. Engaging with local stakeholders from across the target area, we partner on SDOH interventions and funding. In each HE Neighborhood, Nebraska Total Care and our anchor partner will convene CBOs and residents, physical and behavioral health providers, local government agencies, and other stakeholders, making up our ***Neighborhood Councils charged with*** developing a collaborative ***HE Neighborhood action plan.*** We recognize and will leverage the great work being done across Nebraska to reduce health disparities. As part of our approach, we will collaborate with CBOs and leverage existing resources and infrastructure. The action plan identifies resources and services to develop – or in some cases, identifies existing programs to invest in and expand – as part of a coordinated set of health equity interventions across ***three domains: Community, Member, and Provider***.

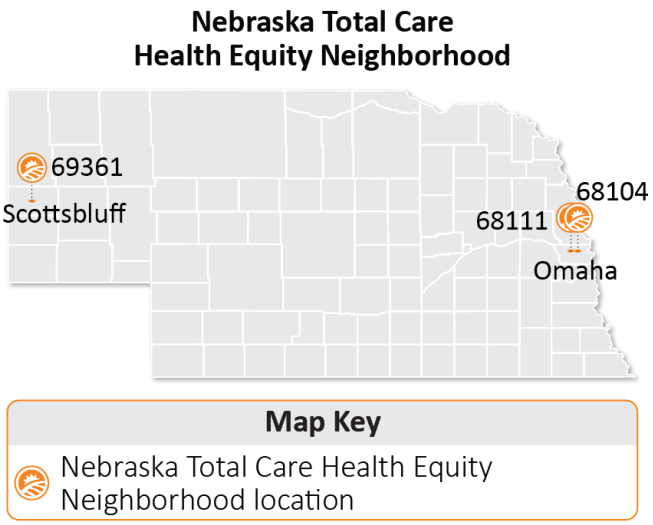
Completing the improvement model, we repeat formative and quantitative analyses and engage stakeholders on a continual basis to evaluate progress on health equity targets and recommend strategies for improvement.

Figure 114.D Health Equity Model

With Communities	Through ***Local Activation and SDOH Partnerships***, we engage Neighborhood Advocates, trusted messengers, and partner with local organizations to expand community interventions that are developed and owned by the people living in the neighborhood.
With Members	Member interventions are designed to reduce disparities in targeted geographic areas. We listen to the needs of members and tailor interventions to reduce disparities, one person at a time.
With Providers	We partner with providers to design clinic-based solutions to promote health equity. We pilot strategies to understand "what works" and incentivize success through health equity VBP models.

Supporting this work is a comprehensive set of health equity tools, such as our ***Neighborhood, Economic, and Social Traits (NEST) predictive modeling tool*** and insights from community resource searches in Nebraska Total Care's social needs referral platform, Findhelp. For example, our NEST tool hotspots" SDOH needs to target community initiatives and identify high-risk members for follow-up. NEST helps us understand social indicators that predict disease burden, enabling us to identify members who may be under-utilizing services but are at risk due to SDOH. This data is also overlaid with health disparity dashboard data to inform our community priorities and identify and align with our HE Neighborhoods.

Nebraska Total Care HE Pilot Neighborhoods. Using the data and tools described, we have identified ***three HE Neighborhoods*** that consist of counties and zip codes with the greatest disparities and SDOH needs for an initial pilot. The three HE Neighborhoods are comprised of two specific zip codes in Omaha (68111 and 68104) and one zip code in Scottsbluff (69361). Although we are implementing the HE Neighborhoods in just three communities initially, our goal is to scale this innovative initiative across Nebraska based on findings and lessons learned from the initial pilot and feedback from local stakeholders.



Disparity and SDOH Analysis. We have identified several HEDIS quality measures with the greatest disparities and opportunity for improvement in these regions that will be the focus of our HE Neighborhood initiative, including timeliness of prenatal care, HbA1c control and testing, antidepressant medication management, and child and adolescent well-care visits. Using both our NEST community analytics and member social needs reported through our SDOH Dashboard, we also overlaid SDOH data for each of the three defined Health Equity Neighborhoods to identify the unique factors likely contributing to disparities in each area. For example, we identified (1) financial literacy / stability, (2) food insecurity, and (3) social isolation as three of the top reported needs across 68104 and 68111, along with significant risk factors around vulnerable minority populations requiring culturally sensitive approaches.

Operationalizing the HEI Neighborhood Initiative. As part of our model, we cultivate trust-based relationships by encouraging transparent and open dialogue. Engagement is a foundation of HE Neighborhoods, using locally run Neighborhood Councils and trusted Neighborhood Advocates, bringing voices together and ensuring a safe place for identifying the needs, priorities, and approaches to reducing disparities. Using an anchor community entity, such as United Way and/or an established neighborhood organization, we will support neighborhood councils and community development activities. With the anchor organizations, we will support health equity research on local lived experience and needs, and partner on SDOH interventions and funding. In direct partnership with community leaders, recognizing their

expertise, lived experience, and the relationships and innovations that already exist, we will convene community-based organizations, members, providers, local government agencies, and other stakeholders to create a new or support an existing Neighborhood Council.

Our goal is to create a forum that elevates the member voice through a participatory process to develop local action plans.

We will actively engage community members and providers and solicit direct feedback through:

- Local representatives on our Neighborhood Councils, Board of Directors, Quality Committees, Health Equity and Diversity Council, and Member and Provider Advisory Councils
- Participation of our leadership team on local boards such as the Nebraska Health Information Technology Board, Statewide Independent Living Council, Assistive Technology Partnership, NEHII Quality Reporting Advisory Council
- Field-based member and provider-facing staff, including Community Health Workers (CHWs) with lived experience
- Community partnerships with entities such as United Way, Heart Ministry, Project Houseworks, Black Family Health and Wellness Association, Center for Holistic Development, and Panhandle Partnership to address and improve health equity
- Use of Memorandum of Understandings (MOUs) to support data sharing and collaboration among key partners

We will enhance our value-based purchasing (VBP) relationships with key providers who serve members in the three HEI Neighborhoods, such as OneWorld, Children's Medical Center and Community Action Health Center, to better align incentives around addressing SDOH and health disparities. New for 2023, Nebraska Total Care is investing in and engaging providers by adding Equity-Based Contracting as a new dimension to our VBP that includes a new health equity incentive based on population risk level. We assess HEDIS metrics by cohort—race and ethnicity groups, rural/frontier and urban populations, and age groups to identify health disparities and develop provider incentives to address them.

HEI Neighborhoods in Action. Nebraska Total Care has the benefit of affiliate experiencing in bringing HEI Neighborhoods to communities in need. For example, our affiliates in California and Louisiana are in various stages of implementation, with established anchor agency relationships and engaged Neighborhood Councils. California was the first to implement HEI Neighborhoods in 10+ neighborhoods over 7 years ago and developed our HEI Model. Louisiana launched their first initiative on maternal and childhood disparities in 2021 with three additional neighborhood initiatives going live in 2022.

Working With Communities. As an example of how we will work with communities to collaboratively address identified disparities, ***Nebraska Total Care is part of the core team that is working to bring a HUB entity to Douglas County, which has high rates of health disparities.*** Focused first on maternal and infant health, the HUB will provide support and education and use life experience to help connect members to community resources through trained CHWs. High-risk mothers in a community HUB service area where the member was not exposed to any community HUB activity were 1.55 times more likely to deliver a baby needing Special Care Nursery or NICU care when compared to high-risk members who received HUB services through delivery.

Working with Members. As an example of how we work with members, Our CHWs provide perinatal coaching to encourage connection to prenatal care and screening completion while licensed BH clinicians support pregnant members with BH needs.

Working with Providers. As an example of how we work with providers, our dedicated Tribal Liaison has bi-weekly check-ins with Tribal 638 health providers, Indian Health Services (IHS), area agency leadership, Urban Indian Health providers, and community leaders, such as Tribal elders. This communication increases awareness, offers a consistent, single point of contact, and helps us stay current on issues and concerns. We meet regularly with the four recognized tribes in Nebraska (Winnebago Tribe, Omaha Tribe, Ponca Tribe, and Santee Sioux Nation) and IHS to understand their specific priorities and build upon the strengths and resources within each Native community.

Doula Program

Our in-person Doula program is in development with direction and guidance from I Be Black Girl. Upon implementation in the fall of 2022 we will also work with Omaha Better Birth Project and other resources as appropriate to ensure accessibility of Doula services for our members.. We have committed to covering doula services for 100 members in three HE neighborhoods, with implementation planned for Fall 2022. As a part of the design process, we are including close communication with all provider partners to monitor outcomes and establish protocols that can be replicated and expanded to additional areas of disparity.

Health Equity Workforce Partnership with Nebraska Association of Local Health Departments (NALHD)

Ongoing engagement is rooted in understanding disparities, using data analytic tools, and purposefully engaging stakeholders who support domains associated with members' health and partners who have a role in where members live, work, eat, play, pray, and receive health

services. Below is an example of a strategic partnership between Nebraska Total Care and NALHD that will be leveraged to address health disparities in each of the NEI Neighborhoods and statewide.

Since 2017, CHWs have been our members' trusted liaisons, recruited and hired from local communities to reflect member demographics. CHWs perform in-person outreach to members lacking phones, assist in finding members to complete assessments, co-locate within communities, and plan and participate in baby showers, health fairs, and other community events. Building upon this foundation, Nebraska Total Care is entering into a strategic partnership with the NALHD to address issues associated with health equity concerns and SDOH through the deployment of CHWs and Program Coordinators directly in community settings, such as schools, daycares, and worksites to screen, educate, and empower diverse community members to address a range of prevention and health care issues. We will accomplish this by placing CHWs and Program Coordinators in Local Health Departments (LHDs) throughout the State. These positions will be members of, or have a unique understanding of, the communities that they serve. They will act as liaisons between public health, health care, behavioral health, social services, and the community to help individuals and communities operationalize behaviors that will prevent or manage disease and address health disparities. Nebraska's LHDs are best positioned to identify risk factors and close need gaps at the individual and community levels. Their reach and impact are currently limited by manpower and an inability to fund positions.

Features of the Program. Nebraska Total Care will provide $2.5 million in funding to advance health equity through workforce development within their communities. In doing so we aim to bridge the gap between clinical and community care by finding sustainable health solutions and prioritizing concerns and resources specific to each individual community served by an LHD. As part of this initiative, Nebraska Total Care will work with NALHD to develop CHW programming and initiatives focused on improving outcomes through:

- Targeting Nebraskans most at risk to experience health disparities, including the Medicaid eligible population, cultural and linguistic minorities, and members at high risk of developing chronic conditions, and pregnant women and children
- Providing connection to social supports that address SDOH, including food and housing insecurities and facilitating access to culturally competent service delivery and language access and assistance
- Improving access to care and better utilization of available resources through championing appropriate use of primary care and ED services
- Increasing vaccination rates
- Lowering HbA1c in individuals with diabetes
- Improving adherence to physician-recommended lifestyle changes

Measurable Benefits

We will monitor and evaluate the effectiveness of our health equity neighborhood initiatives, including the impact of our partnership with the NALHD CHW initiative, by measuring racial, geographic, gender, disability, or other disparities pre-and post-intervention. For example, our Health Equity Dashboard displays performance across priority HEDIS measures by race and ethnicity, using heat maps, tables, and bar charts to see disparities by sub-population and change over time.

The goal of our HEI Neighborhoods is to improve prenatal care, HbA1c control, antidepressant medication management, and child and adolescent well-care visits as those will be our initial focus with our neighborhoods. Additionally, we hope to have successful pilots in 3 neighborhoods and develop a sustainable model for health equity-based contracting that we can model throughout the State.

Intellectual Property (IP) Rights and Ownership

There are no intellectual property rights or patent ownership relating to the above proposed innovation.

Innovation #3: Increasing Access to Dental Services

1. *General Overview*

Dental health is essential to the overall health of our members. In direct response to MLTC carving in dental services into Heritage Health, Nebraska Total Care has developed a comprehensive dental health strategy consisting of innovative programs and solutions to ensure members have access to dental services, including in rural and frontier areas of the State. Features and benefits of our innovative solutions designed to increase access to services are further described below.

Demonstrated Experience. Centene health plans currently manage integrated dental benefits for more than 4 million Medicaid members across 13 states. Nebraska Total Care will leverage the national experience of our affiliate health plans as well as innovative best practices and solutions, described below, to offer an integrated dental benefit in Nebraska.

Expected Lifecyle. The expected life cycle of the program is the term of the new Heritage Health Medicaid managed care contract period.

2. *Features and Benefits*

Increasing Access to Dental Services

We recognize that members in Nebraska, including members living in rural and frontier areas, struggle with access to dental services and experience dental health disparities due to both the scarcity of dental providers as well as long travel times and appointment availability. In response, we are offering the following value-added innovative solutions and strategies to address these challenges by bringing services directly to members and mitigating SDOH barriers and addressing health inequities related to dental health. Many of these solutions have proven successful in other states where our affiliate plans serve members through a Medicaid-managed care contract with an integrated dental benefit.

- **Mobile Dental Vans.** For members living in rural communities, Nebraska Total Care and Envolve Dental are identifying community partners to bring mobile dental vans to community events attended by members and their families. ***Flossy, the Envolve Dental Van***, is scheduled at strategic locations based on health disparity data. Flossy will provide preventive dental service health equity to Nebraskans by offering free, same-day dental health screenings and fluoride varnish with dentists and hygienists. With a focus on education, Envolve's dental van provides high-quality dental health screenings and information. ***Starting in August of 2022, to help prevent dental cavities, we are traveling with Flossy to select counties to offer and apply fluoride varnish to Nebraskans who do not receive regular preventive dental care.***

- **Mobile Anesthesia Services - Bringing Dental Anesthesia to the Office Setting.** We will partner with mobile anesthesia providers to bring dental anesthesia to the dental office setting, to support members living in both rural and urban areas. Dental office anesthesia eliminates wait times and transportation issues members would face in getting to hospitals for dental procedures requiring anesthesia, while reducing ED visits and potential complications. This approach has proven successful among Nebraska Total Care 's sister Medicaid plan in Ohio.
- **Practice Dental Visits - Nebraska Total Care and Envolve Dental will work** collaboratively with our dental providers and community partners to create specialized programs for high-risk members including members with developmental disabilities and other special health care needs. Routinely, members with developmental delay receive preventive dental care in an outpatient hospital setting under general anesthesia. To avoid the additional risks associated with general anesthesia that result from this practice, we will offer to reimburse dentists for rehearsal visits for members to help lessen anxiety and make these visits less stressful. This approach has proven successful among Nebraska Total Care 's sister Medicaid plans in New Mexico and Kansas, allowing members to become familiar with the provider's office, equipment, and processes prior to the actual date of service. It also enables the provider to identify barriers, ensuring clear communication before the appointment takes place.

- **First Tooth, First Dental Visit.** Nebraska Total Care will start a pilot with our partner FQHCs who have medical and dental services to provide dental health education in coordination with primary care. A dental champion (Hygienist or Physician Assistant) will train pediatricians and nurses to provide dental screenings and education to parents at each well-child visit. The champion can also train Pediatricians, Nurse Practitioners, and Physician Assistants to apply fluoride varnish between ages 1 and 3 and make appropriate referral to a dentist when dental disease is suspected.
- **Teledentistry.** To meet members where they are, we offer a teledentistry strategy that expands access to dental care for members with limited access or difficulty traveling to a dentist or dental specialist. We collaborate with our FQHC partners; large hospital systems, and local schools to identify available telehealth services and opportunities for expanding access to dental telehealth. Teledentistry is an opportunity to improve and increase access to integrated

services by bringing teledentistry services to primary care, BH clinics, and school-based health centers. We collaborate with community partners to leverage existing resources and jointly promote access to services across the State. We are exploring a partnership with a local university to expand their teledentistry program, which allows dental providers in rural areas to conduct patient consultations through two-way audio/video with dental specialists at the university. Teledentistry equipment used in this program connects to diverse sites in communities around the State, including a hospital and community health center. Nebraska Total Care has plans to expand these patient consultations to additional rural dental clinics throughout the State.

- **Teledentistry Advice Line.** To provide additional health care service options for members, we provide access to virtual dental services. Members who call the Nurse Advice Line and meet clinically appropriate criteria are offered the option to be transferred to dentists for a telehealth appointment. Through this process, members have access to licensed dentists 24/7, to seek care advice for dental-related issues. As appropriate, our dentists providing telehealth services will refer members for in-office care with an in-network dentist.
- **Reminders for Needed Dental Services.** We empower child members and their families to take responsibility for managing their dental health by providing easy-to-understand, culturally appropriate educational materials. These resources meet the language, reading level, and cognitive and functional needs of members/families. Our communication strategy includes:
  - **EPSDT Reminders.** We use outbound phone messaging and mailers to educate and remind members and their families about annual preventive and EPSDT needs, including the need for sealants and varnishes. Our EPSDT Coordinator works with providers, educating them on the need for referral to dental services.
  - **Follow-up after Emergency Department or Missed Appointments.** We identify members who have used the ED for oral pain or dental-related symptoms. We have a Care Manager or Community Health Worker (CHW) follow up with the member/family. According to the CMS report, Keep Kids Smiling, missed appointments are a major barrier in pediatric preventive care delivery. We work with FQHCs to minimize no-show appointments, identify members who have not received timely dental care, and share contact information with providers who can maximize outreach efforts.
- **Dental Days.** We will offer our community-based Dental Days to promote and increase access to dental care services for children and families. Dental Days begin by building excellent working relationships with our dental provider network. We partner with high-volume dental locations that block off a portion of their day to see members. Our community events include partnering with FQHCs to increase Annual Dental Visit HEDIS rates and sponsoring dental screening events.
- **School-Based Dental Services.** Nebraska Total Care explores programs with an opportunity to bring mobile dental services to school-aged children in Nebraska. Upon identification of these programs, we coordinate with PCPs to target members with dental care gaps by texting and calling members or their guardians to encourage participation. In Missouri, our affiliate health plan has had success with this approach, providing mobile dental services to 70 schools in 24 counties. Additionally, Nebraska Total Care will leverage school-based health programs and partnerships to promote dental health in underserved areas. As part of this initiative, we will provide:
  - Training and education to school-based clinics on completing and being paid for fluoride treatment
  - Toothbrushes, toothpaste, and fluoride rinse for school nurses to keep in their offices
  - Dental health kits in back-to-school giveaways

Expanding Access through Existing Capacity. Beyond our efforts to expand our dental network through contracting, we are taking an active role in expanding capacity with contracted dental providers through assistance with scheduling and follow-up reminders to minimize “no show” appointments, including assisting with transportation, special reminder arrangements, and outbound telephone calls to members prior to appointments. Nebraska Total Care is also committed to using innovative payment models to reward providers and provider groups for improving quality health outcomes and health risk factors for our members as well as decreasing inappropriate utilization of services.

Community Dental Health Expansion Program. Nebraska Total Care partners with the ***Nebraska Association of Local Health Departments (NALHDs) to support their Community Dental Health Expansion program.*** This program maximizes the use of Community Health Workers (CHWs) and dental hygienists as preventive care resources for Medicaid beneficiaries and other patients by expanding the capacity and capabilities of Community Dental Disease Prevention teams in rural Nebraska Local Health Departments (LHDs). We will expand LHD capacity through the financial support of staff time, specialized training, and skill-building of CHWs assigned to LHD dental health programs. Available statewide, this benefit creates a dental health workforce network that strategically coordinates and oversees dental health programs at rural LHDs. Nebraska Total Care along with other MCOs will provide **f**unding to support multiple CHW roles over a three-year period. These positions will complete the Electronic Dental Hygiene Health Records; provide Dental Hygiene education in

local schools, Head Start Programs, and Assisted Living Facilities, Build a Dental Health Resource and Referral Directory for their local area, Manage LHDs' dental health programs, including the Nebraska Department of Health and Human Services Rural Community Dental Disease Prevention Program in each LHD to include completion of all paperwork, scheduling of hygiene activities, setting up and scheduling prevention education programs, partner outreach and oversight of the program.

Measurable Benefits.

Through our Dental QAPI program, we will monitor the outcomes and success of our programs and initiatives to increase access to dental services. Our goal is to incrementally increase the Annual Dental Visit (ADV) HEDIS rate YOY using MCNA's MY2020 total rate for ADV 2-20 years as our baseline.

3. Intellectual Property (IP) Rights and Ownership

There are no intellectual property rights or patent ownership relating to the above proposed

Innovation #4: Strong Start Model of Care for Justice-Involved Members

1. General Overview

Nebraska Total Care's Strong Start Model of Care

Members who are justice-involved or recently released from detention or incarceration often experience unique challenges that impact their ability to successfully transition to the community. These individuals often have a mental illness, substance use disorders (SUD), and chronic conditions. They often experience health disparities, violence, trauma, housing insecurity, economic instability, barriers to employment, and other social factors that impact health outcomes and lead to high rates of recidivism. The risks of relapse, reoffending, and death are highest in the first days and weeks after release, making timely access to care and continuity critical.

To mitigate these risks, we will deploy our Nebraska Total Care ***Strong Start Model of Care*** that consists of our ***Reach-In and Re-Entry Programs supported by Care Coordination and intensive Case Management*** services to ensure members get timely access to services and linkages to community supports.

Our Strong Start Model of Care is guided by the following core principles:

- Incarceration impacts the whole family
- Building trust with the member is central to outreach and engagement
- Our engagement strategies must be flexible, respectful, non-judgmental and follow evidence-based harm reduction, informed care and person-centered principles
- Interventions are based on individualized needs of each member, including length of stay in a detention center or correctional facility, and a good match for the member

Demonstrated Outcomes from Our Affiliate Health Plans. Our parent company, Centene, and several of our affiliate health plans have in-depth experience successfully working collaboratively with the justice and correctional systems through re-entry programs, innovative technology, and evidence-based practices such as housing, supported employment, and peer support to achieve enhanced coordination of care and successful re-entry for members who have been incarcerated. For example, two of our Medicaid managed care affiliate health plans have implemented a similar approach to our Strong State Model of Care with the following positive outcomes highlighted below.

A Nebraska Total Care affiliate health plan successfully engages and serves justice involved members as they enter and move through the justice system. Analysis for 621 justice involved members with serious mental illness (SMI) involved in the program from July 2020 to June 2021 resulted in enhanced access to care. For example, 90 to 100% of members with SMI in four counties successfully engaged in preventive services upon release while on probation.

Another Centene affiliate health plan also partnered with their local justice system through data sharing agreements to support transition planning for inmates both before and after release, resulting in the following outcomes:

- $17k cost savings from less hospitalizations, readmissions, and high engagement in outpatient care
- 97.5% of these members remained enrolled with their health plan
- 78.6% attended their scheduled service appointment after release

Expected Lifecyle of Nebraska Total Care Strong Start Model of Care. Nebraska Total Care will collaborate with MLTC and other correctional and community stakeholders to offer the program to eligible members at the start of the new Heritage Health Contract. The expected lifecycle of the program is five years, the term of the new Heritage Health Medicaid managed care contract period.

2. Features and Benefits

Key Features of Nebraska Total Care's Strong Start Model of Care Program

Our Strong Start Model of Care includes four main features, described below: Reach-in program. Community Re-entry Program, Virtual PCP Model of Care pilot program, and our Housing First Model program.

Reach-In to Jails and Prisons. We have established relationships with key stakeholders to support effective transitions of care that includes our active participation in the Stepping UP re-entry Program in Region 6. We will use this experience as a foundation for our proposed Strong Start Model, that includes collaboration and coordination with MLTC and corrections stakeholders.

Our Justice Outreach Coordinators will provide in-person outreach (reach in services) to the justice-involved population in targeted detention centers and correctional facilities throughout the State. This allows pre-release planning collaboration with members and other contracted state and county entities that provide care in the facility; provides member education on resources and benefits; and facilitates screening and assessments to identify PH, behavioral health, and SDOH needs in collaboration with our Care Management team. In addition to Justice Outreach Coordinators, our Justice Liaison will focus on system engagement to support justice to community transitions. We will begin our program with a pilot with one

correctional facility and evaluate program elements for success before scaling this program to other facilities, including the option of including the Regional Center in the future.

Community Re-Entry Program. Under an optimal scenario, our Justice Outreach Coordinators will identify eligible members 30 to 60 days prior to release. Upon identification, we will provide in-person outreach to educate the member on resources and services available, ensure they have Medicaid eligibility upon release, and begin pre-release planning activities. While we recognize that a solution still in development, Nebraska Total Care proposes to collaborate with MLTC, Nebraska Department of Corrections, and other MCOs to develop systems and processes to support data sharing and coordination. We also welcome the opportunity to help identify best practices for adoption in Nebraska by sharing information on re-entry programs successfully implemented by our health plan affiliates in other states.

Our Re-Entry program will focus on connecting members to supports that have proven effective in community re-integration. In coordination with our Care Management and Community Engagement Teams, including our Justice Liaison and Housing Specialist, the Justice Outreach Coordinator will assess member needs, finalize the transition care plan, and connect members to services and supports post-release, including PH, BH, SUD treatment and dental care; employment and vocational training; educational services; housing; and peer and family support. As part of our model, we will leverage existing resources in the community such as those provided by the Mental Health Association and Safe Harbor to link members to a community-based peer support specialist with shared life experience, which has proven effective in assisting formerly incarcerated individuals in transitioning to the community. ***Our affiliate has had success using peers for justice-involved members. Their justice-involved members who received peer support services demonstrated a 28% decrease in arrests and a 22% decrease in ER visits over 12 months.***

Meeting Members Where They Are. To assist members with the immediate transition and readjustment to community life, Nebraska Total Care's Justice Liaison will arrange for a Peer Support Specialist to meet the member at the time of release if the member chooses. Recognizing this is a critical time in the transition process, we will provide the member with a Nebraska Total Care Cares Package that includes basic hygiene items such as shampoo, soap, razors and shaving cream, deodorant, socks, and underwear, as well as assist with arranging for services offered by Nebraska Total Care, such as transportation and linking the member to other resources based on identified health and SDOH needs.

Post Transition. The Justice-Involved Care Team, which includes the member's assigned Care Manager and Peer Support Specialist, will follow-up with the member immediately after release and through a series of frequent planned contacts to ensure the justice-involved member is stabilized. Transition of care activities will be provided for a minimum of 90 days following the release with a reassessment of needs (including SDOH) and minimum member touch points at monthly intervals. As part of our transition support, our Justice-Involved Care Team will also assist individuals with obtaining IDs, birth certificates, and other documentation necessary to secure housing, employment, and benefits, recognizing how critical these documents are to optimizing outcomes.

Virtual PCP Model of Care Pilot-Babylon Health 360. It is important that inmates with significant physical and behavioral health conditions establish a regular source of care upon release to make sure that there is continuity of care in the provision of needed services. As part of the transition planning process, we are contracting with Babylon Health 360 to pilot our Virtual PCP Model for members re-integrating into the community from incarceration. Our Virtual PCP program is designed to deliver increased access to non-emergent virtual care and care coordination for Nebraska Total Care members during their transition back to the community, regardless of their location, housing, or transportation circumstances post-release. Our goal, working with MLTC, jails, and detention centers is to ensure members have easy access to care post release to ensure continuity and an established relationship with a virtual PCP. As evidence of our commitment to serving this population that experiences health disparities and inequities, we are investing in additional solutions and delivery models to support this at-risk population. We will provide the tools and equipment necessary such as providing members with a ConnectionsPlus phone and services to support adoption of the virtual PCP model of care. Consistent with our commitment to member choice, recently released members may choose their own PCP as their medical home provider in lieu of participating in the Virtual PCP Model of Care.

Addressing Housing Needs. Housing stability is a key component of a successful re-entry and key to preventing recidivism. That is why we are committed to working with private and public partners to address the needs of individuals experiencing unstable housing, including the justice involved.

Nebraska Total Care has developed a unique Housing and Health Continuum framework, called our Housing First Model, which includes engagement strategies, community partnerships, care management activities, SDOH programming, and strategic investments to address the whole person needs of our most vulnerable members, including justice-involved individuals that are re-entering the community. Our Housing First Model is predicated on ensuring our members' basic and whole person needs are met while supporting them along pathways toward housing stability and permanency.

We are in discussion with the University of Nebraska Lincoln, Center on Children Family and the Law, to enable strategic data sharing with Nebraska's Homeless Management Information System (HMIS). This will allow us to proactively identify members who are touching multiple systems, engage and provide them with care management services and link them to health and social services to prevent unnecessary ED visits and recidivism and help them thrive and move to self-sufficiency. Our health plan affiliate that also serves members who reside in rural and frontier communities was the first in the country to integrate directly with the HMIS that has contributed to the following outcomes for Medicaid members:

- 253% increase in wellness visits
- 131% decrease in hospital readmissions
- 69% decrease in inpatient stays
- 50% decrease in crisis services

Measurable Benefits

We will monitor outcomes and success of the Strong Start Model of Care program by monitoring, reporting, and evaluating the following outcomes.

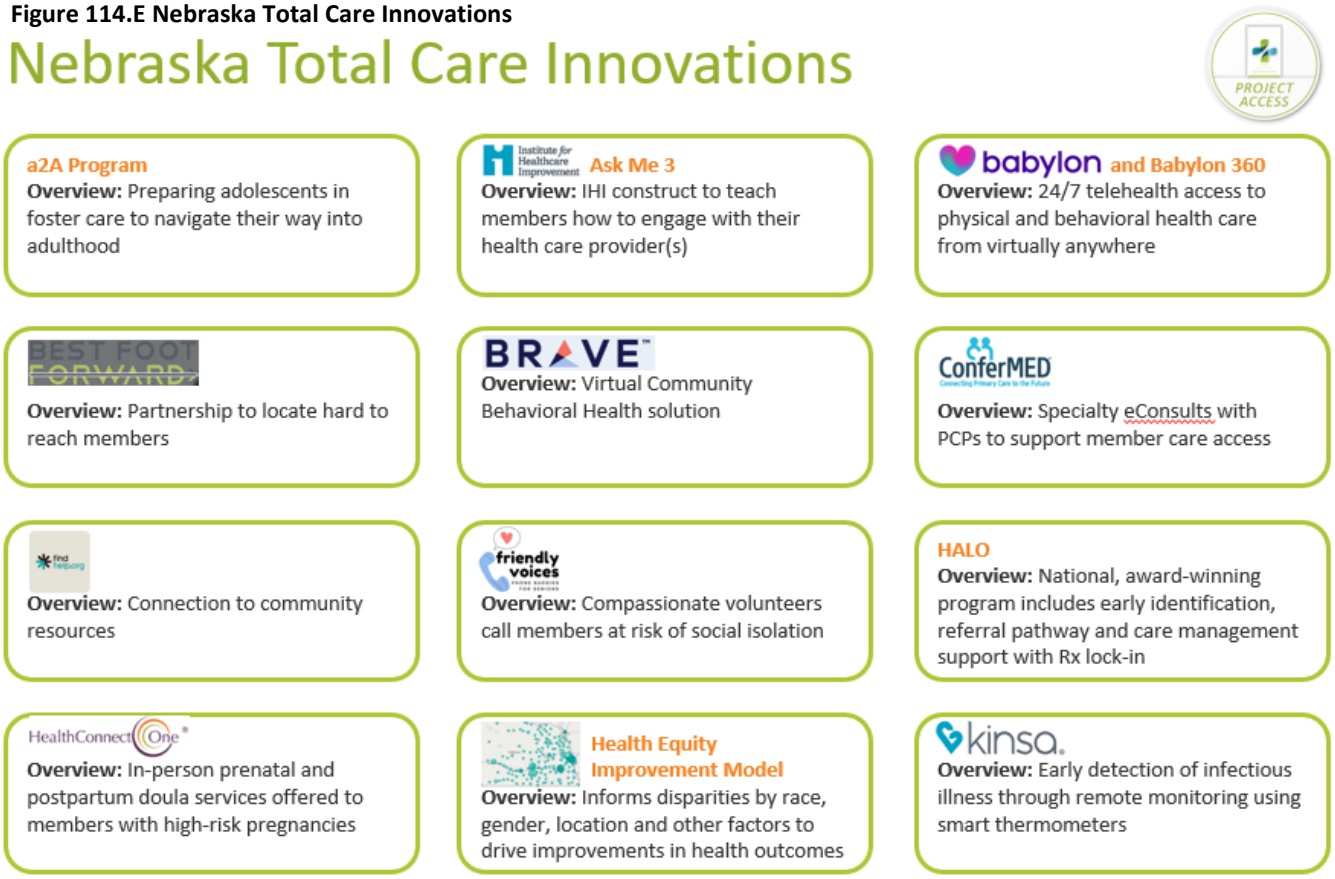
- Virtual care visit within seven days prior to release to 14 days post-release
- Successful completion of Health Risk Screening and SDOH Mini-Screen
- Number and type of community referrals made, including outcome of the referral
- Increase in preventative and wellness visits
- Reduced rate of recidivism

3. Intellectual Property (IP) Rights and Ownership

There are no intellectual property rights or patent ownership relating to the above proposed innovation.

At the heart of improving health equity and outcomes for all Nebraska communities is our ability to innovatively transform health care. Throughout this response, we have described our solutions and partnerships in place as an incumbent MCO and those we plan to implement through this new contract. Following is a summary.

Figure 114.E Nebraska Total Care Innovations



Krames
Overview: Online health library with over 4,000 health-related topics available to members

Member Care Compass
Overview: Multi-faceted member engagement strategy

Mobile Dental Van
Overview: Mobile dental van provides preventive dental service, screenings, and fluoride varnish

Mobility eXchange (BH on Board)
Overview: Tablets and crisis intervention support for first responders

MTM
Overview: Enhanced value-added benefit SDOH transportation

my health pays REWARDS
Overview: Member incentive program to encourage healthy behaviors

myStrength
Overview: Online BH resource tool

NEST Tool
Overview: Used to identify SDOH needs to reduce health disparities

P4P Provider Incentive Program
Overview: Key performance metrics rooted in health outcomes improvement

Pacify
Overview: Virtual lactation support and other doula services

PCHI | Pathways | COMMUNITY HUB INSTITUTE MODEL CERTIFICATION
Overview: Initial Pathway established in Omaha is maternal and child health focused

Pomelo Care
Overview: Virtual group prenatal care to improve birth outcomes

Rapid Response Program
Overview: Pilot with Omaha-based EDs such as CHI CUMC University Campus and CUMC Bergan Mercy Campus

SDOH Mini Screening
Overview: Conducted at PCP and dental offices and via IVR to identify social needs

Sickle Cell Care Management
Overview: Chronic condition management supported by integrated care team

Start Smart for Your Baby
Overview: Maternal and child health program from prenatal through postpartum to ensure healthy pregnancy and delivery

STEPPINGUP
Overview: Initiative to reduce overincarceration of people with mental illness

Supermarket Pharmacy Diabetes Program
Overview: Program with local supermarket to educate members on nutrition and medications