functions, including staff training, staffing level or schedule adjustments, gathering staff feedback, and finding ways to improve coordination among functional areas that impact members and member support.

We leverage disenrollment data to better understand member pain points and implement holistic program improvements. We apply what we learn to our enhanced member welcome experience, taking actions to enhance members' understanding of available tools to access care and support their health journey.

Effective Interventions to Avert Member Disenrollment

Based on our knowledge of why members typically choose to disenroll, we have developed problem-solving interventions such as assistance with navigating the system and providing service recovery solutions that often result in the member choosing to stay enrolled. Our member-facing team works diligently to meet the needs of our over 120,000 members. As noted in **Figure 4.A,** our recent experience reflects our ongoing success in addressing member needs.

Figure 4.A. Effective Member Services Assistance

5. Describe the Bidder's process to identify unborn individuals anticipated to begin coverage at the time of birth. Describe the operational process to obtain identifying information when the unborn status changes to newborn. ***Page Limit: 1***

Process for Identifying Unborn Individuals to Begin Coverage at Birth

Nebraska Total Care successfully manages, on average, over 400 unborn to newborn enrollment ID changes annually for this 599 CHIP eligibility category. We use daily and monthly eligibility and enrollment files (Non-834 Eligibility Data, Supplemental Enrollment Files) sent by MLTC to identify unborn individuals. We load this information into our system to ensure coverage for unborn children of pregnant women who would not otherwise be eligible for coverage under Medicaid or CHIP.

49.6% Increase in Infant Well Visits

We achieved a 49.6% increase in infant well visits over the past two years due to our initiatives focused on engaging pregnant women.

Outreach to Pregnant Women of Unborn Individuals. Our Care Management team conducts outreach to pregnant women receiving services for unborn children in the 599 CHIP category. Our team uses a monthly "599 CHIP Notification of Pregnancy" report from our Centelligence reporting and analytics platform. Upon contact with pregnant women, our Care Management team provides ongoing healthy-pregnancy education and coaching. We encourage them to choose a pediatrician for their babies a minimum of 60 days before the expected delivery date, in compliance with RFP Section V.B.4.d.

Accurate Claims Adjudication. Our Claims Processing System has payment edits requiring members with an unborn ID to have a pregnancy-related diagnosis and ensures payment integrity that aligns with the coverage goals for this rate group. Covered services are limited to prenatal and pregnancy-related services through labor and delivery, in alignment with this eligibility category. This process prevents authorization and reimbursement for uncovered services rendered post-delivery under the unborn member ID.

Providing Education and Administrative Simplification for Providers. We guide our providers on coverage and billing for unborn individuals and newborns. Our posted "599 CHIP" provider guidance describes the unborn child's eligibility, covered and uncovered services, and the bundled rate codes, modifiers, and related descriptions. It also includes brief billing instructions, including using the unborn member's ID and mother's name, a link to the Notification of Pregnancy Form, and a phone number to contact our team. We reiterate this training information through communications such as bi-weekly newsletters and quarterly provider town halls, and it is available on our public website.

Operational Process to Obtain Identifying Information for Newborns

We begin serving members under their newborn ID upon receipt from MLTC and retroactive to their eligibility date. The unborn ID eligibility is terminated at the end of the month of the delivery event. We receive the following identifying information from hospital providers within 24 hours of birth: gender, date of birth, weight, gestational age, Apgar score, type of delivery, and sick/well-baby status. Providers may submit this information via the portal, fax, or phone. If the birth event information is unavailable or otherwise not provided in the authorization request, we request this information in the labor and delivery authorization.

As noted in **Figure 5.A**, the types of services provided relate to the status of the member, with prenatal and pregnancy-related services provided under the unborn ID, and all newborn care provided under the newborn ID. When the status of the unborn individual changes to newborn, the newborn receives a permanent Member ID from MLTC and the provider sends notification of a delivery event to support Utilization and Care Management service coordination.

Figure 5.A. Serving Members with Unborn and Newborn IDs

6. Describe the Bidder's approach to working with other MCOs in the event a member changes their MCO during ongoing operations of the program. Describe how the Bidder will work with other MCOs to ensure a seamless transition and transfer of relevant information. ***Page Limit: 1***

Approach to Working with Other MCOs to Support Member Choice

Our effective processes foster member-centered transitions to and from the other MCOs. Based on the success of our Transition of Care (TOC) program, TOC coordinators are now standard practice amongst MCOs. Our approach ensures seamless transitions without interruptions in access to high-quality care. ***We worked with the other two contracted Heritage Health MCOs to establish a Transition of Care template*** for requesting and receiving member information. The template includes the member's profile, claims data, approved medical and pharmacy coverage authorizations, and enrollment in Care Management or other health management programs. This joint effort between MCOs allows the receiving MCO to adopt any previously approved coverage authorizations and Care Management plans for the member. By collaboratively developing a process that honors approved prior authorizations (PA), captures Care Management assignments, and includes claims information, we provide members consistent, uninterrupted care.

Maintaining Direct Contact with Team Leads at Other MCOs. Our TOC program includes a dedicated TOC Coordinator who promotes streamlined communication with the other MCOs during transitions of care in or out of our health plan. The TOC Coordinator has accountability for obtaining relevant information to add to our TruCare Cloud, including alternative contact information for members who are hard to reach. Our Care Management and Utilization Management Transitions Leads have counterparts at the other MCOs they contact to discuss the needs of members identified as medically complex or having high utilization.

Supporting Nebraska's Youth. Jalen transitioned to Nebraska Total Care from another MCO. Upon receipt of his existing authorization for speech therapy, our Provider Relations Representative contacted the provider to confirm that Nebraska Total Care would honor that existing authorization. The transition was seamless for Jalen and his provider, with no service or claims payment disruptions.

Collaborating in Preparation for the Dental Carve-In. We are working with MCNA and the other MCOs to develop a similar Transition of Care template, so we have information on members with MCNA-approved authorizations or in active Case Management when the dental carve-in goes into effect. Our quarterly meetings with MCNA include ongoing planning regarding MCO-covered dental anesthesia. We will move to monthly meetings three months before go-live, as guided by our dental carve-in implementation plan.

Ensuring Seamless Transition and Transfer of Relevant Information

We understand the importance and complexity of transitioning members into, out of, or between health plans, especially for members with complex conditions and disabilities. Our TOC Coordinator, the single point of contact streamlining communication between entities during transitions of care, is responsible for obtaining all relevant information. Once the information is within TruCare Cloud, it becomes available in our Provider Portal, Community Partner Portal, and to the other MCOs via secure file transfer protocol (SFTP). We initiated system-wide TOC processes and based on the success of our TOC program, TOC Coordinators are now standard practice amongst MCOs.

Transition of Care Success

We successfully complete over 1,200 transitions of care annually.

We have a bi-directional SFTP data exchange process with the other MCOs. Monthly, our Centelligence platform identifies members from the 834 enrollment files newly assigned to Nebraska Total Care from another MCO. We create and upload two files to the SFTP site, one for each MCO, listing members exiting their plan. All three MCOs provide information in the Transition of Care template within three business days. Relevant information includes the member's profile (including spoken language), six months of claims data, approved medical and pharmacy coverage authorizations, and enrollment in Care Management or other health management programs.

Should we face obstacles with receiving information from another MCO, we have escalation procedures and positive relationships with staff at each MCO to support securing member information. If a new MCO receives a contract, we will set up an SFTP exchange, and our TOC Coordinator will reach out to exchange points of contact and provide an orientation to the TOC template and process.

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B. Technical Approach

V.C Business Requirements

V.B Business Requirements

7. Describe the approach the Bidder will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.

Page Limit: Not applicable

Approach to Ensure Compliance with All Relevant Business Requirements

Nebraska Total Care abides by the business requirements in the Scope of Work Section and adheres to the relevant provisions found in 42 CFR, Part 438, Managed Care, Title 471 Nebraska Administrative Code (NAC) Nebraska Medical Assistance Program Services, Title 477 NAC, Medicaid Eligibility, and Title 482 NAC, Nebraska Medicaid Managed Care. Our compliance program reinforces conformity with 42 CFR 438, Titles 471, 477, and 482 of the NAC, and all Federal, State, and ethical standards of conduct while supporting MLTC's goals of achieving the Quadruple Aim for the Heritage Health Program. It builds on the foundation established by our parent company, Centene's Compliance Program, which includes measures related to mandatory compliance training; HIPAA privacy training; fraud, waste, and abuse (FWA) detection, prevention, and correction, including a hotline for anonymous reporting. Our Compliance Program demonstrates to employees, shareholders, providers, and the community, our firm commitment to honest, transparent, and responsible conduct.

Fully Compliant Operations

MLTC performed a virtual on-site review of Nebraska Total Care's general operations, financial records, and quality areas in 2021. MLTC found us fully compliant for all areas of review.

Nebraska Total Care's foundation for compliance is based on guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services (DHHS), which identifies seven elements of an effective compliance program:

- Written Policies and Procedures
- Compliance Officer
- Conducting Effective Training for Employees
- Effective Lines of Communication
- Effective Systems for Routine Monitoring and Auditing
- Enforcement of Standards through Well-Publicized Disciplinary Guidelines
- Effective Systems for Prompt Response to Compliance Issues

Written Policies and Procedures. Nebraska Total Care maintains an extensive library of policies and written guidelines applicable to all associates, directors, Subcontractors, and other business partners that articulate our commitment to compliance with all Federal and State statutory, contractual, and licensure requirements. We review our policies and procedures at least annually and update them as needed to incorporate changes in applicable laws, regulations, and requirements. These policies:

Nebraska Total Care Received 8 Perfect Scores During EQRO Review

We received a perfect score (100% met) for 8 of the 13 standards during our most recent EQRO review performed by HSAG.

- Describe compliance expectations as embodied in the code of conduct
- Outline ramifications and/or penalties for failing to comply with standards of conduct, policies, and procedures, and the failure to act in an ethical manner
- Guide suspected, detected, or reported compliance issues
- Define employees' obligations to report violations of law and policy and the process for communicating compliance issues to appropriate compliance personnel
- Describe how we investigate and resolve suspected or reported compliance issues

Compliance Officer. Nebraska Total Care's Compliance Officer, Jennifer Cintani, oversees our compliance activities. Our Compliance Officer is a full-time employee and Nebraska resident who serves as the Program Integrity Officer and Compliance Officer, reporting directly to the CEO with direct access to the Board of Directors. Our Compliance Officer coordinates, implements, communicates, and monitors our Compliance Program's adherence to 42 CFR, Part 438, and Titles 471, 477, and 482 of the NAC. The Compliance Officer defines our Compliance Program structure, educational requirements, reporting, and complaint mechanisms, response and corrective action procedures, and all personnel and Subcontractors' compliance expectations.

Conducting Effective Training for Employees. Proper training of the Board, management, and all personnel, plus continual retraining of employees, is essential for compliance with Federal and NAC requirements. We require employees to attend specific training during new hire orientation and annually. Centene University, our personalized learning platform, provides a combination of instructor-led and self-directed learning available 24/7. Topics include an overview of Federal and NAC

requirements and additional training for member-facing employees and other staff with increased responsibilities. Our Compliance Program training consists of a review of our business ethics, policies, and practices that reflect current legal and program standards. Employees can access training (in-person, virtually, and via newsletters) regarding the standards of conduct and procedures for alerting senior management to problems and concerns. Our training platform sends training alerts and completion reminders to employees and their supervisors. Reminders escalate to senior staff and the Compliance Officer as the targeted training completion date approaches.

The Compliance Officer and our Human Resources department document the completion of all compliance training. Employees, based on role, must complete a minimum number of educational hours per year as part of their employment responsibilities. Participation in training is a condition of continued employment and a component of each employee's annual evaluation. Our Corporate Ethics and Compliance staff annually evaluate the contents of our training and education program to ensure subject content is appropriate and contemporary to cover the range of issues facing employees. Further, we keep the training content up to date with any changes in laws, rules, regulations, provisions of NAC, and Federal requirements. We inform Subcontractors of training requirements through initial onboarding, annual reminders, and attestations.

Effective Lines of Communication. Nebraska Total Care maintains processes to submit, record, and respond to compliance questions or reports of potential or confirmed non-compliance from officers, directors, managers, associates, members, Subcontractors, and related entities. Our processes preserve confidentiality to the extent possible, allowing anonymity if desired and ensuring non-retaliation against those who report suspected misconduct. We publicize mechanisms to receive compliance questions, reports of potential risks, and reports of FWA from employees, members, Subcontractors, and related entities through the following lines of communication:

- **Employees:** Group and department meetings, email reminders, posters in high-traffic office areas, compliance awareness articles published on CNET, our company intranet site, and leadership talking points to encourage compliance discussions at department levels
- **Members:** Handbook, website, monthly service verification forms, Member Portal
- **Providers:** The Provider Handbook, provider updates, newsletters, and provider website
- **Subcontractors:** Mailings and attestation forms

To support prompt and effective communication, employees may contact our Compliance Officer, CEO, and Board of Directors; Centene's Corporate Compliance Officer; the Compliance Hotline; or make a report online through CNET. Employees can report issues in person, submit issues anonymously, view policies, and learn more about our business's laws, regulations, and standards of conduct. We consistently communicate new regulations, updates to the NAC, regulatory changes, or contract changes. On an annual basis, we remind Subcontractors and network providers on methods of reporting compliance issues.

Effective Systems for Routine Monitoring and Auditing. Effective compliance programs identify problems as they occur. Ongoing reviews and proactive scanning and detection position us to quickly address any identified problems. Our system for routine monitoring, auditing, and identification of compliance risks includes:

- Dedicated staff for routine internal monitoring and auditing of compliance risks, based on our annual compliance auditing and monitoring plan
- Evaluating trending activity over time to assess patterns and variations, which is tracked using our Compliance Management System tools
- Unannounced audits of Subcontractors to assess their compliance with contract requirements related to delegated functions and ongoing monitoring of Subcontractors' key performance indicators (KPIs)

We perform periodic compliance audits using internal or external auditors with expertise in Federal and State health care statutes, regulations, and Federal health care program requirements. The audits and reviews focus on our compliance with specific rules and policies that have been the focus of attention by regulatory bodies or legislation. Monitoring techniques include sampling protocols that permit the Compliance Officer to identify variations from the baseline.

The Compliance Officer, with the assistance of department managers, develops a snapshot of operations from a compliance perspective. This assessment is sometimes supported using independent, outside consultants, law, or accounting firms with authoritative knowledge of health care compliance requirements. This snapshot, used as part of benchmarking analyses, becomes the baseline for the Compliance Officer and other managers to judge our progress in reducing or eliminating potential areas of vulnerability. Significant variations from the baseline trigger an inquiry to determine the cause of the deviation. If the deviation was caused by improper procedures, misunderstanding of rules, including fraud, and systemic problems, Nebraska Total Care promptly corrects the problem and monitors the following correction to ensure the problem has been fully resolved.

The Compliance team prepares and presents a compliance plan to the Compliance Committee annually and updates the compliance work plan at least quarterly. The compliance plan includes privacy and security; auditing, monitoring, and oversight; risk monitoring and reporting; screening; vendor oversight; training; FWA; regulatory reporting; and monitoring, investigating, and reporting.

The Compliance Committee supports our Compliance Officer in the ongoing review and oversight of the compliance program, including performing an annual review. During quarterly meetings or on an ad-hoc basis, the Compliance Committee reviews the compliance program's effectiveness by monitoring self-audit results, metrics, and key indicators and ensures prompt, effective corrective actions are taken if they identify deficiencies.

Enforcement of Standards through Well-Publicized Disciplinary Guidelines. We maintain policies, procedures, and training materials that provide clear, specific disciplinary standards and expectations for compliance and reporting issues related to non-compliance or illegal activity. We promptly and consistently act per our disciplinary or enforcement standards when we find non-compliant activity. We publicize disciplinary guidelines to all employees and encourage reporting incidents of unethical or non-compliant behavior, including through compliance training, articles and videos published on our CNET intranet site, posters displayed in common work areas, and live presentations. We maintain records of disciplinary actions for a minimum of 10 years, including the date and description of the violation, investigation date, and findings.

Effective Systems for Prompt Response to Compliance Issues. Our Compliance Management System allows us to administer and monitor internal governance and provides contractual and regulatory oversight capabilities. Our system provides workflow-enabled policy and procedure formulation with a complete history of documentation and signature approvals. It distributes documents to the appropriate internal departments and Subcontractors and tracks compliance activities with auditable records of management approval, contract, and regulatory mandates. The system tracks and stores ongoing compliance risk assessments.

Violations of our compliance program, failures to comply with applicable Federal or State law, and other types of misconduct threaten our status as a reliable, honest, and trustworthy organization capable of participating in government-sponsored health care programs. Detected, but uncorrected misconduct can seriously endanger our mission, reputation, and legal status. Consequently, upon reports of suspected noncompliance, the Compliance Officer or designee initiates prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred and if so, take steps to correct the problem. Such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan (CAP), or a report to the State or Federal authorities.

Depending on the nature of the alleged violations, an internal investigation typically includes interviews and reviewing relevant documents. We may engage outside counsel, auditors, or managed care experts to assist in an investigation. Investigation records contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and critical documents, and investigation results, for example, disciplinary action is taken, or CAP implemented. The Compliance Officer reviews the circumstances to determine if similar problems have previously occurred. If the Compliance Officer believes the integrity of an investigation may be at stake because of the presence of employee(s) under investigation, we remove them from their current work activity until the investigation is complete (unless an internal or government-led undercover operation is in effect). The Compliance Officer takes appropriate steps to prevent the destruction of documents or other relevant evidence.

If we determine that disciplinary action is warranted, it is promptly imposed following Nebraska Total Care's written standards of disciplinary action. Corrective actions fix the underlying problems that result in program violations and prevent future misconduct. We tailor CAPs to address the misconduct identified. A CAP provides a structure with timeframes to disallow continued misconduct. When developing CAPs, we document all CAP requirements and include ramifications in the event the CAP is not satisfactorily implemented and monitored to ensure it is followed through.

Approach to Ensure Compliance with New Requirements

Heritage Health requirements continue to evolve through State plan amendments and other regulatory updates. We also seek to adopt MLTC goals, such as administrative simplification and health equity. When MLTC communicates additional requirements, our Compliance Team monitors for, downloads, posts, and distributes any updates and leads training, monitoring, and audit activities for the implementation-related activities.

We Promptly Address New Requirements

Provider Bulletin 21-05 stipulated a time-sensitive update to the nursing facility's per diem reimbursement rate, increasing the rate by $20 per day. We updated our systems within 30 days, processed new claims at the revised rate and reprocessed all claims previously paid at the lower rate. In alignment with our focus on administrative simplification, no action was required by the provider.

State plan amendments, health plan advisories, and Provider Bulletins are the basis for most of these updates. However, we may receive regulatory and other communications directly from MLTC corporate communications and other sources. In 2021, for example, MLTC issued 24 Provider Bulletins and 7 health plan advisories which were evaluated by the Compliance Team and department leaders to ensure our ongoing compliance with Federal and State requirements. The Compliance Team promptly distributes updates and ensures they are reviewed across all applicable departments. Each functional area confirms its understanding and identifies required actions, providing a response to the Compliance Team to track the following:

- Functional area impact analysis
- Level of risk
- Identified action plans with timelines and cross functional area collaboration dependencies
- Weekly status updates
- Action plans completion dates
- Verification date of solution implementation

Each functional area identifies needed updates to its policies and procedures, tools, and resources, prepares an implementation plan, or adds these elements to existing implementation plans. ***Our department leaders respond to required actions within one business day of receiving a Health Plan Advisory, Provider Bulletin, and any regulatory updates.*** We evaluate new requirements for impact on members and Subcontractors:

- **New Requirements Impacting Providers.** Upon notification of new requirements for providers, we communicate and collaborate with providers to review and comply with all updates to maintain compliancy.
- **New Requirements Impacting Members.** We evaluate the impact of new requirements on members, and if appropriate, communicate the updates with them. For example, when transportation was carved in, we conducted an email campaign leading up to the implementation to help members arrange transportation on day one and not miss any appointments as a result.
- **New Requirements Impacting Subcontractors.** Our Vendor Manager contacts Subcontractors to review new requirements. As needed, we issue an amendment to our existing Subcontractor agreement to reflect the changes.

Proactive Compliance Evaluation by a Separate Internal Team. Centene's Corporate Compliance team evaluated Nebraska Total Care's compliance program in 2021 against the Office of Inspector General's seven elements of an effective compliance program. This compliance activity by a quasi-independent internal team provides us with guidance for supporting the maturation of the compliance program. The Corporate Compliance team compares health plan tools, processes, and outcomes across Nebraska Total Care's affiliate health plans to inform best practice adoption. The resulting program evaluation report provided to our Compliance team in Fall 2021 confirmed our program continues to mature as expected and is in line with comparable plans in other markets.

Recent Assessment by HSAG, the External Quality Review Organization. We actively seek information to guide improvements in our operations. The External Quality Review Organization's (EQRO's) report is one opportunity to identify areas for improvement. Health Services Advisory Group (HSAG) conducted their initial review of Nebraska Total Care in 2021, as a full operational review. We received a perfect score (100% met) for 8 of the 13 standards. The review findings concluded that we met MLTC's and HSAG's response requirements. We were receptive to all recommended actions and implemented process improvements to enhance ongoing operations.

8. Describe how the Bidder meets the Federal definition of an MCO. The MCO must have a Certificate of Authority (COA) to transact the business of health insurance in Nebraska as a health maintenance organization (HMO) by the contract start date. If the MCO is not licensed as required by the Nebraska Department of Insurance at the time of proposal submittal, the MCO must attest that the appropriate licensure will be obtained before executing a contract with MLTC.

Page Limit: 1 Excluding copy of COA

How Nebraska Total Care Meets the Federal Definition of an MCO

Nebraska Total Care meets the Federal definition of an MCO, as noted in 42 CFR 438.2:

- We have, and are competitively bidding to be re-awarded, a comprehensive risk contract
- We are a private entity that meets the advance directives requirements of 42 CFR 489.100
- We make the services we provide our Medicaid members as accessible as those services are to other Medicaid beneficiaries within the area served by Nebraska Total Care
- We meet the solvency standards of 42 CFR 438.116

Nebraska Total Care COA

Nebraska Total Care meets the business requirements related to RFP Section V.C.2. Our COA to transact the business of health insurance in Nebraska as a health maintenance organization (HMO), is provided in **Attachment B.8 Certificate of Authority**.

9. Describe the Bidder's proposed approach for collaboration with other entities and programs, as required in Section V.C.5.Business Requirements – Cooperation with Other Entities and Programs

Page Limit: 3

Approach for Collaboration with Other Entities and Programs

Nebraska Total Care regularly collaborates with other entities and programs across Nebraska. Working together, we share input through workgroups and committees supporting MLTC-aligned planning and system transformation. As we gain insight from the perspective of other entities, we improve our member-facing education, training, and resources to meet members' whole-health needs. Our approach to collaboration is holistic and person-centered. We recognize that optimal health outcomes require integrating the full range of services and support into an individualized system of care around the member, based on their unique health risks, needs, and preferences.

We educate our staff on how to serve members from a system of care-informed perspective. Member-facing staff training includes person-centered training, motivational interviewing, waiver services, eligibility requirements, enrollment and referral protocols, coordination of benefits for dual-eligible members, the transition of care coordination, and protocols for cooperating with other community-based and facility-based service coordinators. We invite collaborating entities to share information related to their programs during "lunch and learn" sessions. By working together, our staff learns how to make our programs as complementary and seamless as possible to each member, breaking down historical silos of care.

We have a Community and Disability Liaison, Foster Care Liaison, Tribal Liaison, and System of Care Liaison within our Care Management team. Our liaisons have extensive relationships within our members' systems of care and regularly meet with each of them, including Waiver Coordinators, Tribal partners, and Probation and Foster Care Coordinators.

Division of Behavioral Health (DBH) Funded Programs. Our BH Manager collaborates with DBH to support the behavioral health of our members and stakeholders by attending Assertive Community Treatment and Matrix intensive outpatient care meetings to address barriers and enable access to services. We work with the Lincoln Regional Center Treatment program to provide successful transitions for members. We are members of the Metro Suicide Coalition, participate in 988 webinars and training, and attend Nebraska Partnership for Mental Health Access in Pediatrics meetings. Supporting these programs builds our competencies around members' experiences and gaps in care, and we appreciate being proactive and collaborative partners in creating solutions.

Division of Child and Family Services (DCFS) Funded Programs. Nebraska Total Care's Foster Care Liaison serves as the main point of contact for the DFCS and the Nebraska Office of Juvenile Justice and Delinquency Prevention (OJJDP), attending Health Care Oversight Committee meetings, quarterly MCO meetings, and system of care meetings. Our Foster Care Liaison attends member staffing meetings with DCFS and OJJDP to discuss child welfare- or juvenile probation-involved members with high BH needs, Physical Health (PH) needs, or high-risk behaviors. Case discussions may include a review of medication, diagnosis, current and available services, and other Care Management support, including for those members aging out of the Foster Care System. Our Foster Care Liaison builds awareness and coordination across our organization to meet the needs of DCFS and OJJDP members.

Our Foster Care Team Collaborates with DCFS to Support Overwhelmed Foster Parents. Nick, a 5-year-old in foster care, was at risk of institutional care due to his medically fragile condition and foster parents feeling overwhelmed by his needs. Our Care Manager, Kim, collaborated with our Foster Care Liaison, DCFS, and our clinical team to provide the maximum benefit for home health services and respite. Kim worked with home health agency providers to coordinate services and mediate existing communication gaps between the providers and the foster parents, greatly reducing the parents' anxiety. Nick was able to successfully have his needs met in his foster home despite his ongoing fragile condition.

Division of Development Disabilities (DDD) Programs. Nebraska Total Care's Community and Disability Liaison is our lead collaborator with the DDD. We participate in the Liberty Health Contractor Workgroup to provide input and prepare for changes to all Home and Community-Based Services (HCBS) waivers. We participate in the Housing Workgroup as a subcommittee to the Olmstead Advisory Committee to build members' access to community-based housing. Due to DDD's extensive role in supporting multiple waivers, our Liaison has regular discussions with DDD. Our liaison facilitates ongoing collaboration with case managers for all HCBS waivers in Care Management so that we can continue to help members live independent lives in their community of choice. We obtain the Plan of Services and Supports (POSS) and the Individual Family Service Plan (IFSP) documents, when applicable, to fully align to the needs and goals of the individuals and their programs.

Helping 'James' Access Services and Stable Housing. James was experiencing housing instability, had unaddressed physical health needs, and had multiple recent inpatient psychiatric admissions and ED visits for behavioral health (BH) reasons. After multiple unsuccessful attempts to engage James, our Care Manager (CM) engaged James' mother, who indicated James was on the waitlist for developmental disability services. Our CM coordinated a meeting with James' mother and the Division of Developmental Disabilities (DDD) to discuss James' situation. The DDD determined James was eligible for emergency funding based on his BH needs and housing instability and approved placement at an independent living home. Once James was stably housed, our CM helped him access ongoing care for his BH and PH needs and participate in vocational rehabilitation.

The Nebraska Department of Education Early Development Network. Our Community and Disability Liaison has developed strong relationships with Service Coordinators in the Early Development Network throughout Nebraska. Our Liaison collaborates with Service Coordinators to provide comprehensive care coordination, guided by the IFSP, to our members and their caregivers.

Community Agencies Including AAAs and League of Human Dignity Waiver Offices. Nebraska Total Care's Community and Disability Liaison is the lead collaborator with the eight AAAs and the League of Human Dignity Waiver Offices (League). Our Liaison, Joni Thomas, is a Council Member for the Statewide Independent Living Council (SILC), serving their second term, alongside the Executive Director of the League of Human Dignity. The SILC is a Federally mandated body that creates and guides a triennial State Plan for Independent Living to ensure coordinated planning and financial support of services for individuals with disabilities. SILC is composed of members of the disability community and State agencies such as Medicaid, Vocational Rehabilitation, Assistive Technology Partnership (ATP), Client Assistance Program, Commission for Deaf and Hard of Hearing, and Commission for the Blind and Visually Impaired. As a Council Member for SILC, our liaison updates us on what is trending and changing within the disability community services structures and allows Nebraska Total Care to build and sustain relationships with all SILC attendees.

Our liaison's ongoing, collaborative relationships with the AAAs and the League improve our ability to share member documentation, such as the POSS. Our collaboration ensures we properly utilize waiver dollars, that our funds cover items not already covered by a waiver, and that our focus remains on helping individuals live safely in their community.

Assistive Technology Partnership

We work with ATP to help members needing a home or vehicle modifications, durable medical equipment, and other unique unfunded needs. Our Community and Disability Liaison chairs the ATP Advisory Board, and we support ATP's continued success in assisting members.

MCNA Dental (MCNA Insurance Company and Managed Care of North America, Inc.). Since 2020, we have worked with MLTC's current dental MCO, MCNA, collaborating to coordinate care, identify opportunities that support access and the use of dental services for Medicaid members, promote holistic dental health as part of overall whole-person health, and mutually identify Care Management opportunities to support equitable health access in Nebraska.

Office of Probation. Our Care Management team partners with the Office of Probation to support Nebraska Total Care members on probation. These discussions include case collaboration on resources, placement issues, identification of barriers to member success, and any identified gaps in care. Care Management provides the Office of Probation staff with educational materials and training on our Care Management process, the benefits of Care Management, and how to navigate key resources on our website.

Initiatives to Promote Service Integration. The Nebraska Integrated Health Care Task Force promotes full integration of primary and BH care models and services for adults with serious mental illness (SMI) and co-occurring PH conditions, chronic disease, or substance use disorders. The Task Force is comprised of 13 members that collaborate across key stakeholder entities. Participants include senior leaders from DHHS, MLTC, Department of Public Health, DHHS Communication and Legislative Services, the Association of Local Health Directors, Community Alliance, two Regional Behavioral Health Authorities, National Alliance on Mental Illness of Nebraska, Indian Child Welfare Coalition, and Nebraska Total Care. Adam Proctor, COO, provides advice as a Task Force member to inform policies and processes that support a fully integrated health care model for adults with SMI.

To achieve pharmacy management objectives, our Population Health team meets monthly with a clinical team at MLTC to discuss members who are drug utilization outliers or experiencing barriers within the health care system. We collaborate and share guidance on pharmacy solutions that can positively impact members. Our Director of Pharmacy attends the bi-annual MLTC Pharmacy and Therapeutics meetings and State Drug Utilization Review Board meetings to collaborate with external pharmacists, prescribers, and other committee members. Together they provide care for not only Nebraska Total

Care members, but all Medicaid members who are enrolled in Medicaid fee-for-service or another MCO.

Tribal Entities. Our Tribal Liaison, Jennifer Newcombe, collaborates with the Tribal communities in monthly meetings and on-site visits. We outline our resources and processes during our quarterly Tribal Health Advisory Committee meeting. Our Tribal Liaison shares best practice guidelines and brainstorming sessions with the Tribal communities on an ongoing basis to raise awareness of community resources. We collaborate with Tribes to implement initiatives that benefit our Tribal members in receiving culturally appropriate, timely, and effectively engaged care.

"I am writing this letter to give my endorsement to Jennifer Newcombe and Nebraska Total Care as this company competes for a Managed Care contract with Nebraska Medicaid. Throughout Jennifer's work as a Tribal Liaison, she has always been responsive to our questions and concerns with all billing questions and patient care. In most cases, she has gone above and beyond making sure our concerns are taken care of, not just on her level but that of Senior Management. Working with Nebraska Tribes has not been an easy task; however, Nebraska Total Care has streamlined the process, so our questions and concerns are taken are of in a timely manner. Nebraska Total Care has been extremely dedicated to the Ponca Tribe of Nebraska Health Department and I highly recommend they be considered for the next round of contracts."

-Rebecca Crase, Director of Business Office, Ponca Tribe

Examples of Coordination Activities with Tribes. Through our ongoing work with the Tribes, we have been able to support the unique needs of each sovereign Tribe, including:

- **Omaha Tribe and Winnebago Tribe BH Crisis Support.** We coordinated with the Omaha Tribe's and Winnebago Tribe's local, community-based medical and BH providers to provide mental health resources in support of individuals experiencing a BH crisis, and during the current baby formula shortage was able to provide baby formula, diapers, wipes, and other supplies to the Omaha Tribe to fill a critical need.
- **Santee Sioux Tribe Flooding Services.** Our Care Management team identified members with emergent needs due to flood waters obstructing access to care. We provided equipment, travel, and other community resources. We coordinated with our vendor, Envolve Vision, Inc., to provide eyeglasses cases, repair kits, and lens cleaning cloths to the Santee Sioux community.
- **Winnebago Tribe and Omaha Tribe Foster Care Summit.** Our Foster Care Liaison and Tribal Liaison met with DHHS Foster Care Supervisors and Social Workers from the Winnebago Tribe and Omaha Tribe to improve our processes to better meet the health and needs of tribal members receiving foster care services.
- **Ponca Tribe Care Management Services.** Our Quality and Care Management Directors assisted in the development of Ponca Tribe engagement in Care Management including Diabetic counseling for members with high-risk factors, resulting in a 34% increase in tribal services and Care Management.
- **Tribal Members Aging Out of Foster Care.** We mail a backpack and a hygiene/toiletry kit to Tribal Members aging out of foster care to engage them in Medicaid re-enrollment to avoid gaps in coverage.
- **Baby Showers.** In partnership with Nebraska Urban Indian, based in Lincoln, our Care Management team has been engaged in sponsoring and participating in baby showers for the Tribal communities.

We regularly receive supportive feedback from the Tribal communities for recognizing and respecting their sovereignty and unique programs and approaches.

"I just wanted to reach out and 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 that were sent to our facility to help with the pandemic during the past two years. The communication that you, as our Tribal Liaison, have provided is one that we will forever appreciate. It is a pleasure to work along with you and we appreciate your prompt attention to our facility and billing department needs. I hope to keep this business partnership for years to come."

- Crystal Appleton, Business Office Manager, Carl T. Curtis Health Ed Center

Collaboration with Other MCOs. We have a history of working with the other two MCOs. We have taken a lead role in simplifying administrative procedures, such as creating common Behavioral Health service authorization forms and Provider

PCP Change Forms. Additionally, we worked collaboratively with the other MCOs to successfully implement and train providers on Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology alongside MLTC, 3M, Navigant, and Optum. Our plan president and CEO, Heath Phillips, is the president of the MCO Association, guiding ongoing cross-MCO initiatives and administrative simplification.

Supporting Ongoing MLTC-Identified Planning Initiatives and System Transformation. Our work aligns with MLTC's ongoing priorities. For example, in support of MLTC's goals to meet the needs of diverse members, our Diversity, Equity, and Inclusion (DEI) Council partners with the community to host "lunch and learn" sessions from diverse organizations such as the Omaha Black Plains Museum, The Omaha Star, NAACP, Out Nebraska, Japanese Hall and History Project, Center for Disability and Inclusion, and Heartland Pride. Our DEI team celebrates Heritage Months and aligns these celebrations with outside organizations to provide our employees an opportunity to learn about diverse cultures from members' community organizations. This bridge to our community results in more culturally aware Care Managers.

10. Describe if any of the Bidders Medicaid MCOs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska MCO. Please describe any unsuccessful accreditation attempts in other states.
Page Limit: 1

NCQA Accreditation

Nebraska Total Care meets the business requirements related to RFP Section V.C.3. We are NCQA accredited and pursuing Health Equity accreditation with our review scheduled for October 2022. ***We received a 99% overall NCQA Standards score and 100% in 4 of the 6 Standards categories during our February 2022 renewal audit***. Additionally, our parent company, Centene, has significant accreditation experience. As of April 2022, Centene maintains 28 Health Plan Accreditation statuses for Medicaid products, including Nebraska Total Care. Seven of these health plans have earned Long Term Services and Supports (LTSS) Distinction and four have achieved Health Equity Accreditation.

Health Plan	Accreditation Through	Health Plan	Accreditation Through
California Health & Wellness	5/2/2025	Harmony Health Plan, Inc. (MS)	6/11/2022
Health Net of California Inc.	5/2/2025	Nebraska Total Care	2/25/2025
Sunshine Health Plan (FL)	2/2/2025	NH Healthy Families	8/20/2024
Peach State Health Plan (GA)	5/22/2023	WellCare Health Plans of New Jersey, Inc.	3/11/2023
Ohana Health Plan (HI)	2/11/2024	Western Sky Community Care (NM)	3/26/2024
Iowa Total Care	9/7/2024	SilverSummit Healthplan (NV)	1/30/2023
Meridian Health Plan of Illinois, Inc.	2/11/2023	Fidelis Care (NY)	1/25/2024
Managed Health Services (IN)	10/14/2022	Buckeye Health Plan (OH)	2/22/2025
Sunflower State Health Plan (KS)	4/13/2023	Trillium Community Health Plan (OR)	1/7/2025
Wellcare Health Insurance of Kentucky, Inc.	9/18/2023	Pennsylvania Health & Wellness	11/19/2022
Louisiana Healthcare Connections	5/27/2023	Absolute Total Care, Inc. (SC)	8/28/2022
Meridian Health Plan of Michigan, Inc.	12/24/2022	Superior Health Plan (TX)	2/18/2024
Home State Health Plan (MO)	8/3/2023	Coordinated Care Health Plan (WA)	5/6/2023
Magnolia Health Plan (MS)	1/8/2023	MHS Health Wisconsin	9/6/2022

= LTSS Distinction = Multicultural Distinction

Commitment to Health Equity. NCQA Distinction in Multicultural Health Care identifies organizations leading the market in providing culturally and linguistically sensitive services and working to reduce health care disparities. Beginning in 2022, NCQA is offering Health Equity Accreditation, recognizing health care organizations that evaluate and address health disparities. Our commitment to health equity includes:

- Our parent company, Centene, received a 2021 Innovation in Health Equity Award from NCQA.
- Nebraska Total Care is scheduled for an NCQA Health Equity Accreditation survey in October 2022. Six other Centene health plans are scheduled in 2022 and 2023.
- In January 2022, Health Net, a Nebraska Total Care affiliate, was selected as one of nine health organizations to help develop NCQA's Health Equity Accreditation Plus program, which will build upon their recently launched Health Equity Accreditation program.

No Unsuccessful Accreditation Attempts in Other States

We conducted a comprehensive multi-year look back at Centene's NCQA accreditation history and Nebraska Total Care's affiliate health plans in other states have had no unsuccessful accreditation attempts. This shows our commitment to quality improvement across all levels of plan operations.

11. If the Bidder elects to not provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish this information to MLTC with its proposal to this RFP. The information provided must be consistent with the requirements of 42 CFR 438.10. Describe how the Bidder will provide members with access to those services.

Page Limit: 1

Nebraska Total Care attests that we have no moral or religious objections to providing, reimbursing, or providing coverage for any MCO-covered services, including counseling and referral services. We fully comply with the requirements of 42 CFR § 438.10.

RFP 112209 O3

Attachment B.8
Certificate of Authority

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

NEBRASKA TOTAL CARE, INC

DOMICILED IN THE STATE OF NEBRASKA

IS HEREBY AUTHORIZED AND LICENSED IN NEBRASKA TO TRANSACT THE BUSINESS AS A HEALTH MAINTENANCE ORGANIZATION (HMO) IN THE STATE OF NEBRASKA AS DESCRIBED BY CHAPTER 44 OF THE INSURANCE STATUTES OF NEBRASKA:

59227813	May 01, 2022	April 30, 2023
NEBRASKA IDENTIFICATION NUMBER	**DATE ISSUED**	**DATE EXPIRES**

SIGNED AT LINCOLN, NEBRASKA

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1ST 1867

DIRECTOR OF INSURANCE

RFP 112209 O3

B. Technical Approach

V.D Staffing Requirements

V.D Staffing Requirements

12. Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract.

Page Limit: 3 Excluding organizational chart

Nebraska Total Care – Company Background

Established to deliver quality health care in the State of Nebraska through local and community-based resources, Nebraska Total Care is a subsidiary of Centene Corporation (Centene). ***As an incumbent Medicaid MCO, we are ingrained in the community and have served Medicaid and CHIP members in Nebraska since the inception of the Heritage Health program in 2017.*** Nebraska Total Care is structured to deliver on our mission of improving the health of the community, one person at a time. Our highly qualified staff, many of whom have been with Nebraska Total Care since implementation, have the knowledge and skills to compassionately serve our diverse community, deliver equitable services, and develop innovative strategies. We are committed to local accountability, and 85% of the Nebraska Total Care staff are located in Nebraska. By augmenting our local expertise with additional support from our corporate functional experts, affiliates, and subcontractor staff, we have been able to advance our organizational goals and culture despite an extremely competitive labor market. Our organizational structure, including all operational areas, will continue to support truly integrated delivery of physical health, behavioral health, pharmacy programs, vision, non-emergency medical transportation (NEMT) and for the new contract, the addition of dental services, into a single comprehensive and coordinated program for members.

Nebraska Total Care's Organizational Information

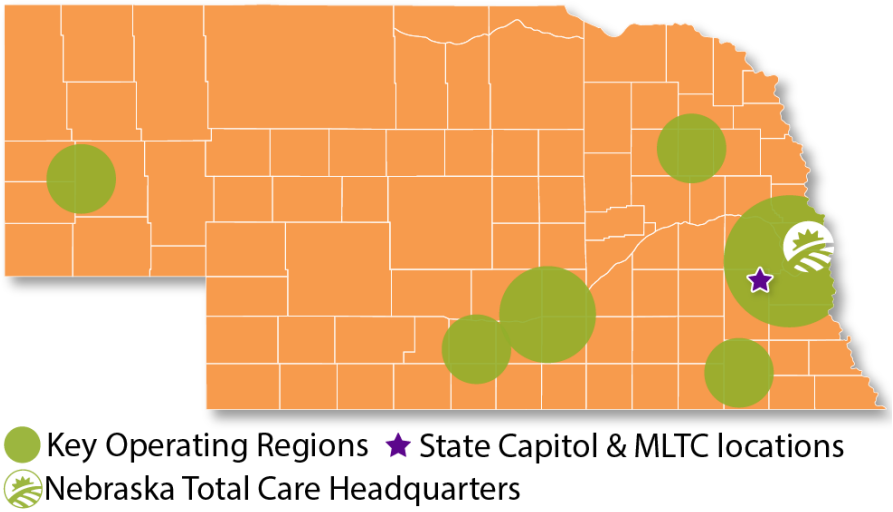
Number of Employees. Nebraska Total Care currently has more than 200 employees and will ensure all new staff are hired and trained by the start of the new contract.

Lines of Business. Nebraska Total Care manages the following lines of business in Nebraska:

- ***Medicaid: Heritage Health and Heritage Health Adult.*** Our Medicaid managed care product in all 93 counties in Nebraska currently serves more than 120,000 members.
- ***Medicare Advantage: WellCare.*** Our Medicare product has 3 HMO and 3 PPO products, which currently serve over 4,200 members in 37 counties. We plan to expand in Nebraska in 2023. Our Medicare products include a Highly Integrated Dual Eligible (HIDE) Special Needs Plan (SNP).
- ***Marketplace: Ambetter from Nebraska Total Care.*** Our statewide health insurance Marketplace product in all 93 counties currently serves approximately 14,000 Nebraskans.

Office Location. Nebraska Total Care's headquarters address is 2525 N. 117th Avenue, Suite 100, Omaha NE, 68164. As we demonstrate in **Figure 12.A**, Nebraska Total Care employees work in locations throughout the State, strengthening our understanding of members in communities across Nebraska. The areas in green represent the home communities of our Nebraska-based employees, demonstrating the correlation between our staff and population density.

Figure 12.A Nebraska Total Care Staff Community Locations



Nebraska Total Care Employees Work Across the State. Nebraska Total Care's office in Omaha places our center of operations close to the majority of members and the largest provider groups in eastern Nebraska. We also recognize the diverse lived experience in urban, rural, and frontier areas of the State and seek to be accessible to all members and providers. As such, we prioritize hiring practices that create geographical disbursement of staff similar to the greater population.

Organizational Chart – Nebraska Total Care

Attachment B.12 Nebraska Total Care's Corporate Structure Organizational Chart illustrates our corporate ownership structure and lines of responsibility and authority in the company including our parent organization and affiliates that will support this contract. The organizational chart includes the following entities:

Incumbent Bidding Entity. Nebraska Total Care is the RFP respondent and incumbent bidding entity. We hold a statewide Health Maintenance Organization (HMO) license issued by the Nebraska Department of Insurance and are a wholly-owned subsidiary of Centene Corporation (Centene).

Parent Organization. Nebraska Total Care's parent organization is ***Centene Corporation (Centene)***. Centene, a Fortune 50 company, is a leading multi-line health care enterprise that provides programs and services to government-sponsored health care programs, focusing on under-insured and uninsured individuals. Centene has over 38 years of experience in full-risk managed care and currently serves over 15 million Medicaid members across 29 states.

Board of Directors. Nebraska Total Care's Board of Directors (BOD) is our governing body and has legal and fiduciary responsibility for operations and operates per Nebraska law and regulations. To support the new requirements for the addition of integrated dental services, we are committed to adding a practicing dentist to our BOD to ensure this new service is integrated at the highest level of the organization.

Affiliates. **Table 12.A Nebraska Total Care's Affiliates Who Will Support the Heritage Health Contract** lists and describes the companies that will support the Heritage Health Contract; they are affiliates of Nebraska Total Care and 100% owned by Centene Corporation.

Table 12.A Nebraska Total Care's Affiliates Who Will Support the Heritage Health Contract

Affiliate Name and Ownership Information	How Company will Support Nebraska Total Care and the Heritage Health Contract
Centene Management Company, LLC (CMC), 100% owned by Centene Corporation	Through a management agreement with Centene Management Company, LLC (CMC), Nebraska Total Care receives administrative support services including 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 Medication Therapy Management.
Envolve Dental, Inc. (Envolve Dental), 100% owned by Centene Corporation	Integrated dental benefit management services. Nebraska Total Care will collaborate with Envolve Dental to ensure that dental benefits are coordinated and integrated with each member's whole-health needs. Envolve Dental provides services in 29 states where Centene manages Medicaid health care contracts. Envolve Dental began supporting Nebraska Total Care in 2022.
Envolve Vision Inc. (Envolve Vision), 100% owned by Centene Corporation	Integrated vision benefit management services. Nebraska Total Care will collaborate with Envolve Vision to ensure that vision benefits are coordinated and integrated with each member's whole-health needs. Envolve Vision provides services in 29 states where Centene manages Medicaid health care contracts.
National Imaging Associates, Inc. (NIA), 100% owned by Centene Corporation	Radiology benefits management services and therapies – PT/OT/ST including utilization management, provider credentialing and recredentialing, network development and maintenance, and appeals.

Subsidiaries. Nebraska Total Care does not have subsidiaries.

13. Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart."
Page Limit: Not applicable

Nebraska Organizational Charts – Nebraska Total Care

Nebraska Total Care organizational charts are included as **Attachment B.13 Nebraska Total Care Organizational Charts.** These organizational charts include our ***proposed key staff*** and ***additional required staff***. A list of the names of our proposed key staff for each required position is provided below in **Table 13.A Nebraska Total Care's Proposed Key Staff.** In addition, **Table 13.B Differentiator Positions That Enhance Programs** includes a list and brief description of other differentiator positions that are either currently in place or will be hired before the implementation of the new contract. These positions will increase our ability to impact the health outcomes of our members and achieve the goals set forth by MLTC.

Nebraska Total Care's Organizational Charts Provided as Attachment. **Attachment B.13 Nebraska Total Care Organizational Charts** is included with this submission and provides a representation of Nebraska Total Care's organization by functional area on separate pages.

- **Chart A – Nebraska Total Care Overview**
- **Chart B – Population Health and Clinical Operations Including Dental, Care Management, Utilization Management, and Behavioral Health**
- **Chart C – Quality and Pharmacy**
- **Chart D – Operations, Compliance, and Finance**

Proposed Key Staff. The following proposed key staff are listed in **Table 13.A Nebraska Total Care's Proposed Key Staff** and included in our Nebraska Total Care organizational charts. We have intentionally selected a leadership team and key staff who have well-rounded backgrounds and significant experience in health care. Their knowledge and experience will continue to be beneficial to our members because they bring unique insights that help navigate the system and remove barriers. Twenty-three of 25 proposed key staff are part of the Nebraska Total Care team today, familiar with the current contract, and will continue to manage and exceed the requirements for the new Heritage Health contract. More importantly, retaining these staff members will provide continuity for the State and our members.

Key Staff Know Heritage Health

23 of the 25 key staff positions are filled by Nebraska Total Care team members who are currently serving Nebraska Medicaid members today.

Table 13.A Nebraska Total Care's Proposed Key Staff

#	Proposed Key Staff Title *Based in Nebraska	Nebraska Total Care Health Plan (Incumbent) Current Titles	Nebraska Total Care Proposed Key Staff Name
1.	Chief Executive Officer (CEO)*	Plan President & Chief Executive Officer (CEO)	Heath Phillips
2.	Medical Director/Chief Medical Officer*	Chief Medical Director	Dr. Chris Elliott
3.	Dental Director	Senior Director Dental Services	Actively recruiting
4.	Dental Management Coordinator	Dental Director	Dr. Jonathan Rich
5.	Behavioral Health Clinical Director	Behavioral Health Medical Director	Dr. Wendy Welch
6.	Behavioral Health Manager*	Manager, Behavioral Health	Darla Wynia
7.	Chief Operating Officer (COO)*	Senior Vice President, Operations	Adam Proctor
8.	Chief Financial Officer (CFO)*	Plan Chief Financial Officer (CFO)	Phyllis Thompson
9.	Program Integrity Officer*	Vice President, Compliance	Jennifer Cintani
10.	Grievance System Manager*	Manager, Grievance & Appeals	Cynthia Meraz
11.	Business Continuity Planning and Emergency Coordinator	Manager, Compliance	Kimberly Betts
12.	Contract Compliance Officer*	Vice President, Compliance	Jennifer Cintani
13.	Quality Management (QM) Coordinator*	Vice President, Quality & Process Improvement	Aimee Black
14.	Performance and Quality Improvement Coordinator*	Data Analyst IV (Healthcare Analytics)	Jeremiah (Jeremy) Blake

#	Proposed Key Staff Title *Based in Nebraska	Nebraska Total Care Health Plan (Incumbent) Current Titles	Nebraska Total Care Proposed Key Staff Name
15.	Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	Senior Manager, Quality Improvement	Susan Jeffrey
16.	Medical Management Coordinator*	Vice President, Population Health & Clinical Operations	Nancy Laughlin-Wagner
17.	Provider Services Manager*	Senior Director, Contracting & Network Development	Timothy Easton
18.	Member Services Manager*	Director, Member Service	Dee Kohler
19.	Claims Administrator	Manager, Claims	Aimee Reis
20.	Provider Claims Educator	Senior Manager, Provider Relations	Mariana Johnson
21.	Case Management Administrator*	Director, Clinical Operations	Paula Stapleton
22.	Information Management and Systems Director	Director, Data Analysis	Trisha Henthorn
23.	Encounter Data Quality Coordinator	Director, Data Analysis	Trisha Henthorn
24.	Tribal Network Liaison*	Manager, Strategic Provider Partnerships	Jennifer Newcombe
25.	Pharmacist/Pharmacy Director*	Director, Pharmacy	Jamie Benson

List of Nebraska Total Care's Additional Required Staff. The following additional required staff, as listed in Section D. Staffing Requirements of the RFP, are included in our Nebraska Total Care organizational charts provided as **Attachment B.13.**

- Prior authorization staff
- Prior authorization dental staff
- Concurrent review staff
- Concurrent dental review staff
- Clerical and support staff
- Provider services staff
- Member services staff
- Claims processing staff
- Encounter processing staff
- Care management staff
- FWA investigative staff
- A Non-Emergency Medical Transportation (NEMT) Network Coordinator
- Care management and utilization management staff including multidisciplinary clinical staff, Care Coordinators, and Care Managers
- A local individual to serve as a liaison for behavioral health providers and dental providers

Other Differentiator Positions That Enhance Programs

The following other differentiator positions are proposed in addition to the RFP's required key staff and required additional staff. They are either currently in place or new proposed positions that will increase our ability to impact the health equity and wellness outcomes of our members and achieve the goals set forth by MLTC. These differentiator positions are placed on their respective organizational charts and listed in **Table 13.B Differentiator Positions to Enhance Programs** by title, and name, and provides a brief position description.

Table 13.B Other Differentiator Positions to Enhance Programs

#	Differentiator Position Title and Name	Position Description
1.	**Senior Health Equity Specialist:** ***Amy Wing***	Our Senior Health Equity Specialist reports to the Quality Management Coordinator and works with the Quality Management department to maintain compliance with regulations and contractual obligations of Culturally and Linguistically Appropriate Services (CLAS) and Health Equity for Medicaid and Medicare product lines. She ensures that culturally and linguistically appropriate services are provided to members, including identifying and

#	Differentiator Position Title and Name	Position Description
		implementing health equity initiatives, representing the health plan on national, regional, and multi-plan initiatives, and assessing operations for gaps. Ms. Wing leverages feedback from providers, members, vendors, and community-based organizations in the development of strategy and implementation. She makes recommendations for CLAS and Health Equity efforts as aligned with contractual, accreditation, and quality improvement opportunities to senior management. Ms. Wing has been with Nebraska Total Care since 2018. In addition to this position, she also serves as an Initiative Facilitator on the HEDIS Work Group, CLAS Task Force Lead, Health Equity and Diversity Council Chair, and Member Advisory Committee Quality Representative. She has over 24 years of experience in health care as a registered nurse specializing in maternal and child health.
2.	**Community and Disability Liaison, and Pathways Facilitator:** ***Joni Thomas***	Joni Thomas is our Community and Disability Liaison. In this role, she provides consultation to Nebraska Total Care staff on waiver and disability issues, serves as the point of contact with the Division of Developmental Disabilities (DDD), supports member's care teams, and provides internal staff training on available State resources and how to assist members in accessing them. She meets regularly with our System of Care Liaison and Foster Care Liaison. This team acts as the dedicated point persons for their assigned State agencies and programs and works in concert to anticipate and resolve systemic coordination and communication issues and quickly meet the needs of HCBS waiver providers, Division of Children and Family Services (DCFS), or other State programs. Ms. Thomas has worked with Nebraska Total Care since 2017. Disability and Advocacy have been themes in her career over the last 36 years as she has worked in multiple roles in a variety of settings in the State including working for the Center for Independent Living (CIL), and for the State of Nebraska.
3.	**Foster Care Liaison:** ***Michelle Muhle***	Our Foster Care Liaison is responsible for the Care Coordination of our Heritage Health child foster care members which includes ensuring members have access to needed social, community, medical, and behavioral health services. Ms. Muhle collaborates with the Department of Social Services to review service plans for child foster care members and makes recommendations and referrals for case management. She performs member outreach, evaluation, and assessments, and coordinates services between Foster Care staff, primary care physician (PCP) specialists, the health plan case management team, and other medical and non-medical providers as necessary to meet the complete medical and socio-economic needs of foster care members. In addition, she provides training for parents and foster care guardians. Ms. Muhle has been with Nebraska Total Care since 2019. She has 14 years of experience working in the Child Welfare field including 6 years working directly with children and families. She has completed extensive training and presents on various topics related to child abuse and neglect to community stakeholders in Nebraska.
4.	**System of Care Liaison** ***Actively Recruiting***	We are actively recruiting for a System of Care (SOC) Liaison to join our Care Management team. Our SOC Liaison will report to the Director, of Clinical Operations and work with our Population Health and Clinical Operations (PHCO) and Care Management and teams to develop and maintain relationships with Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and the I/DD communities, to support coordination of care for aligned and non-aligned dual-eligible and non-dual eligible members. The SOC Liaison will maintain collaborative relationships with Health and Family Services, government agencies, and community resource and advocacy groups, to build additional community support for current and potential Heritage Health members in Nebraska. In addition, our SOC Liaison will identify additional support systems, including other Medicaid waivers, as possible options to meet member needs.
5.	**Telehealth Specialist:** ***Mariana***	Our Telehealth Specialist guides and supports providers who have general questions about telehealth, need help getting started or are having difficulties using telehealth services. Ms.

#	Differentiator Position Title and Name	Position Description
	Johnson	Johnson is involved in discussions and decisions related to telehealth initiatives, programs, and strategies to ensure access to care for members. Ms. Johnson has been with Nebraska Total Care since 2016. She has 12 years of experience developing, supporting, and executing performance strategies to support provider networks and 16 years of experience coaching, managing, and supervising high-performance teams to meet business outcomes.
6.	**Senior Manager, Marketing and Communications/ Community Engagement and SDOH Navigator:** *Jamaree Maack*	Ms. Maack leads the Marketing and Communications team and is the SDOH Navigator for Nebraska Total Care. Ms. Maack and the staff who report to her are responsible for developing new and strengthening existing relationships with Community Organizations and other key stakeholders throughout the state. She contributes to many of Nebraska Total Care's successful community partnerships, resulting in ongoing initiatives throughout the State that have helped members overcome hurdles such as housing instability, food insecurity, and conditions that can be barriers to success and health. She directs statewide investments in annual sponsorships that have paved the way for Nebraska Total Care to continue supporting community initiatives. Additionally, she and her team facilitate the Member Care Compass programs to increase member engagement in care. Ms. Maack has been with Nebraska Total Care since 2016. She has 12 years of experience in Medicaid managed care with 14 years' prior experience in community-based organizations serving children and families and 20 years of leading highly successful teams in program development and innovation to improve services in Nebraska.

14. In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3-month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."
Page Limit: Not applicable

Proposed FTEs by Time Period – Nebraska Total Care

In **Tables 14.A Proposed FTEs by Time Period – Key Staff** and **14.B Proposed FTEs by Time Period – Additional Required Staff** we indicate the proposed number of FTEs for key staff and additional required staff for discrete time periods (no longer than 3-month intervals) from contract award through 6 months after the start date of operations (anticipated contract start date is July 1, 2023) and whether positions are located in Nebraska.

Staff Serving Heritage Health Members in Nebraska Since 2017

Nebraska Total Care was established to deliver quality health care in the State of Nebraska through local, regional, and community-based resources. As an incumbent, we are ingrained in the community and have served Medicaid and CHIP members in Nebraska since the inception of the Heritage Health program in 2017 and successfully incorporated Heritage Health Adult in 2020. We already have our highly experienced team in place in Nebraska to manage the current contract and will have all proposed key and additional required staff in place for the new contract. All staff required to be located in Nebraska, are located in Nebraska.

Proposed FTEs by Time Period

Table 14.A Proposed FTEs by Time Period – Key Staff

FTEs by Time Period									
#	Key Staff Title *Must be based in Nebraska	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-Start	Contract Start	3 Months Post-start	6 Months Post-start	Located in NE (Y/N)
1.	Chief Executive Officer (CEO)*	1	1	1	1	1	1	1	Y
2.	Medical Director/Chief Medical Officer*	1	1	1	1	1	1	1	Y
3.	Dental Director	0	1	1	1	1	1	1	Y
4.	Dental Management Coordinator	1	1	1	1	1	1	1	N
5.	Behavioral Health Clinical Director	1	1	1	1	1	1	1	N
6.	Behavioral Health Manager*	1	1	1	1	1	1	1	Y
7.	Chief Operating Officer (COO)*	1	1	1	1	1	1	1	Y
8.	Chief Financial Officer (CFO)*	1	1	1	1	1	1	1	Y
9.	Program Integrity Officer*	1	1	1	1	1	1	1	Y
10.	Grievance System Manager*	1	1	1	1	1	1	1	Y
11.	Business Continuity Planning and Emergency Coordinator	1	1	1	1	1	1	1	Y
12.	Contract Compliance Officer*	1	1	1	1	1	1	1	Y
13.	Quality Management (QM) Coordinator*	1	1	1	1	1	1	1	Y
14.	Performance and Quality Improvement Coordinator*	1	1	1	1	1	1	1	Y

FTEs by Time Period									
#	Key Staff Title *Must be based in Nebraska	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-Start	Contract Start	3 Months Post-start	6 Months Post-start	Located in NE (Y/N)
15.	Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	1	1	1	1	1	1	1	Y
16.	Medical Management Coordinator*	1	1	1	1	1	1	1	Y
17.	Provider Services Manager*	1	1	1	1	1	1	1	Y
18.	Member Services Manager*	1	1	1	1	1	1	1	Y
19.	Claims Administrator	1	1	1	1	1	1	1	Y
20.	Provider Claims Educator	1	1	1	1	1	1	1	Y
21.	Case Management Administrator*	1	1	1	1	1	1	1	Y
22.	Information Management and Systems Director	1	1	1	1	1	1	1	Y
23.	Encounter Data Quality Coordinator	1	1	1	1	1	1	1	Y
24.	Tribal Network Liaison*	1	1	1	1	1	1	1	Y
25.	Pharmacist/Pharmacy Director*	1	1	1	1	1	1	1	Y

Table 14.B Proposed FTEs by Time Period – Additional Required Staff

We provide the proposed number of FTEs by time period for additional required staff in **Table 14.B** below. We will meet all in-state staffing requirements.

FTEs by Time Period									
#	Additional Required Staff	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-Start	Contract Start	3 Months Post-start	6 Months Post-start	Located in NE (Y/N)
1.	**Prior authorization staff**	8	8	8	8	8	8	8	Y
2.	**Prior authorization dental staff**	0	0	1	1	1	1	1	N
3.	**Concurrent review staff**	9	9	9	9	9	9	9	Y
4.	**Clerical and support staff**	4	4	4	4	4	4	4	Y
5.	**Provider services staff**	16	16	16	16	16	16	16	Y
6.	**A local individual to serve as a liaison for behavioral health providers**	4	4	6	6	6	6	6	Y

FTEs by Time Period									
#	Additional Required Staff	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-Start	Contract Start	3 Months Post-start	6 Months Post-start	Located in NE (Y/N)
	and dental providers								
7.	**Member services staff**	31	31	31	31	31	31	31	Y
8.	**Claims processing staff**	10	10	10	10	10	10	10	Y
9.	**Encounter processing staff**	6	6	6	6	6	6	6	Y
10.	**Care Management staff**	19	19	19	19	19	19	19	Y
11.	**FWA investigative staff**	6	6	6	6	6	6	6	Y
12.	**A Non-Emergency Medical Transportation (NEMT) Network Coordinator**	1	1	1	1	1	1	1	Y
13.	**Care Management and utilization management staff including multidisciplinary clinical staff, Care Coordinators, and Care Managers**	67	67	67	67	67	67	67	Y

15. Provide job descriptions (including education and experience qualifications) of employees in key staff positions.
Page Limit: 1 page per job description

Job Descriptions for Required Key Staff Positions

As **Attachment B.15 Job Descriptions,** we provide a one-page job description (including education and experience qualifications) for each of the 25 required key staff positions listed in **Table 15.A Heritage Health Job Descriptions for Nebraska Total Care Key Staff.** All job descriptions include the minimum duties listed for each role as required by *Table 1. Key Staff in Section D. Staffing Requirements* of the RFP.

Twenty-three of the 25 proposed key staff are part of the Nebraska Total Care team today, familiar with the current contract, and will continue to manage and exceed the requirements for the new Heritage Health contract. For the positions required for integrated dental services in the new contract, we have hired a qualified and experienced professional to fill the Dental Management Coordinator position and we are actively recruiting for a Dental Director.
As required, we will continue to maintain written job descriptions for each key staff position and functional area, and review all job descriptions on an annual basis, at a minimum, to ensure they reflect current practices.

Table 15.A Heritage Health Job Descriptions for Nebraska Total Care Key Staff

#	Proposed Key Staff Title (State's Position Title in the RFP) *Based in Nebraska	Nebraska Total Care Health Plan (Incumbent) Current Titles
1.	**Chief Executive Officer (CEO)***	Plan President & Chief Executive Officer (CEO)
2.	**Medical Director/Chief Medical Officer***	Chief Medical Director
3.	**Dental Director**	Senior Director Dental Services
4.	**Dental Management Coordinator**	Dental Director
5.	**Behavioral Health Clinical Director**	Behavioral Health Medical Director
6.	**Behavioral Health Manager***	Manager, Behavioral Health
7.	**Chief Operating Officer (COO)***	Senior Vice President, Operations
8.	**Chief Financial Officer (CFO)***	Plan Chief Financial Officer (CFO)
9.	**Program Integrity Officer***	Vice President, Compliance
10.	**Grievance System Manager***	Manager, Grievance & Appeals
11.	**Business Continuity Planning and Emergency Coordinator**	Manager, Compliance
12.	**Contract Compliance Officer***	Vice President, Compliance
13.	**Quality Management (QM) Coordinator***	Vice President, Quality & Process Improvement
14.	**Performance and Quality Improvement Coordinator***	Data Analyst IV (Healthcare Analytics)
15.	**Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator***	Senior Manager, Quality Improvement
16.	**Medical Management Coordinator***	Vice President, Population Health & Clinical Operations
17.	**Provider Services Manager***	Senior Director, Contracting & Network Development
18.	**Member Services Manager***	Director, Member Service
19.	**Claims Administrator**	Manager, Claims
20.	**Provider Claims Educator**	Senior Manager, Provider Relations
21.	**Case Management Administrator***	Director, Clinical Operations
22.	**Information Management and Systems Director**	Director, Data Analysis
23.	**Encounter Data Quality Coordinator**	Director, Data Analysis
24.	**Tribal Network Liaison***	Manager, Strategic Provider Partnerships
25.	**Pharmacist/Pharmacy Director***	Director, Pharmacy

16. Describe how the Bidder's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, dental, and pharmacy services.

Page Limit: 4

Nebraska Total Care's Structure to Support Integration of Services

Established in 2017 to deliver quality health care in the State of Nebraska through local and community-based resources, Nebraska Total Care's administrative structure and practices have successfully supported the integration of the delivery of physical health, behavioral health (BH), vision, and pharmacy services for the Heritage Health program since its inception and the addition of NEMT services during the current contract. For the new contract we will:

- Continue to use our Management Information System (MIS) to provide full integration of covered health care services, including the new dental services benefits.
- Continue to integrate pharmacy benefit management through our subcontracting relationship with CaremarkPCS Health (CVS) and our 6 years of local knowledge informing our day-to-day approach.
- Incorporate integrated dental services through our trusted and experienced affiliate Envolve Dental. We will support the full integration of dental services by:
  - Incorporating dental data into our care management, reporting, data from CyncHealth HIE, and Member, Provider, and Community Partner Portals.
  - Integrating dental staff and external dental experts on our care teams, leadership management teams, Quality Assessment and Performance Improvement Committees (QAPIC), and Board of Directors.

Seamless Integration of Services Since 2017

Our delivery of seamless integration of services for Medicaid members in Nebraska began in 2017, grew with the implementation of Heritage Health Adult Medicaid expansion in 2020, and incorporated Medicare products including HIDE SNP in 2022.

We will continue to combine a local approach enhanced by the experience and infrastructure of our parent company and Medicaid affiliates. Twenty-four of our Medicaid affiliates support successful similar integrated delivery models. We will draw from our experience in Nebraska and our affiliates' models of care and expertise to ensure our administrative structure and practices support the integration of all services for the new contract.

Integrated Personnel to Support Integrated Care

Nebraska Total Care and our parent company's organizational structure was designed with the primary goal of integrating services, and our senior leadership supports and promotes a culture of integrated services. This integration has brought focused expertise and created a seamless experience for our members and providers. ***A fully integrated staffing model*** at the health plan has the full continuum of staff working collaboratively at both the health plan and subcontractor levels to ensure whole-person care is delivered seamlessly.

Delivering an Integrated Staffing Model Before the Operational Start Date. Nebraska Total Care's organizational structure will directly support the integration of physical health, BH, dental, vision, NEMT, and pharmacy services for all members. For the new Scope of Work, all key staff are in place today, with the exception of the Dental Director, which we are actively recruiting.

Our leadership team includes our ***Behavioral Health Clinical Director*** who works in tandem with our ***Chief Medical Officer*** (as well as their direct reports) to ensure that all plan services and functions are built upon and advance whole-person, integrated care principles. Reporting to the Behavioral Health Clinical Director, our ***Behavioral Health Manager*** will continue to engage with staff across the organization to ensure BH program operations are appropriately integrated throughout.

Our staffing model is designed to support cross-discipline collaboration that creates an atmosphere of innovation. Our BH, Disability Coordination, Foster Care, and Nursing staff are embedded throughout Nebraska Total Care and will continue to work within and across departments to support the integration of services and supports. Specifically:

- Our Population Health and Clinical Operations teams include clinical and non-clinical staff with a range of experience and expertise to fully support all members, including those with co-occurring conditions.
- Our Network Development and Contracting team includes integrated ***Behavioral Health Provider Relations Representatives*** and utilizes ***Quality Practice Advisors*** to work to advance integrated care models through the Patient-Centered Medical Homes and Accountable Care Organizations.
- Our QAPIC structure drives ongoing improvement and refinement of integrated care activities, including through the identification and spread of best practices and lessons learned. Our BH Advisory Committee includes our Chief Medical

Officer, Behavioral Health Manager, and Pharmacy Director to better identify and inform opportunities to improve the integration of services and supports.

We also hold quarterly Vendor Oversight meetings with our key service benefit partners including Envolve Dental, Envolve Vision, MTM for non-emergency Medical Transportation (NEMT), and CVS account representatives. Additionally, we hold a monthly pharmacy meeting that specifically addresses Tribal health issues to alleviate disparities and promote health equity.

Integrated Multi-Disciplinary Care Teams. Nebraska Total Care ensures the integration of services through a holistic care management program design. Our integrated care teams include Registered Nurses, BH clinicians/social workers, Pharmacy Coordinators (Clinical Pharmacists), and Dental Coordinators (State licensed dentists or dental hygienists). Our Care Management program is modeled after the evidence-based Integrated Case Management program promoted by the Case Management Society of America (CMSA). Our person-centered approach to Care Coordination creates an individualized system of care around each member that addresses the functional, social, and other non-clinical needs that have an impact on health and quality of life. Our approach collapses silos often found in traditional care management by training care team professionals, regardless of expertise, in techniques that allow them to provide interdisciplinary assistance. Care team staff are trained to include all aspects of wellness – physical, BH, dental, medication, and SDOH into a member's plan of care.

Integrated Systems to Support Integrated Care

Integrated services are administered through people, processes, and technology ***already operational for the Heritage Health contract today***. Our commitment to integrated, whole-person care is evidenced by our fully integrated staff and the following systems, which are fully operational today and well prepared to integrate dental services under the new contract.

- ***An MIS*** that integrates physical health, BH, vision, dental, and pharmacy data for clinical management and reporting.
- ***Data-driven informatics and predictive analytics***, which capture physical health, BH, vision, dental, and pharmacy data, through our Centelligence reporting and analytics platform and Enterprise Data Warehouse (EDW). Our secure EDW integrates data such as internal eligibility, claims, care management, utilization management, and provider data system, as well as external data from our providers, CyncHealth HIE, MLTC, and CMS (for our Nebraska Medicare HIDE SNP). This data integration allows our Centelligence health care analytic applications to provide timely reports, drill-down dashboards, HEDIS and other outcome measures, and care gap alerts, all in the service of clinically integrated Care Coordination.

Integrated and Interoperable MIS to Enable Coordinated Care. Care integration requires data integration and timely bi-directional data sharing. In terms of integrated physical health and BH, key components of our interoperable MIS include systems such as TruCare Cloud our collaborative Service Coordination and Utilization Management platform, Centelligence reporting and analytics platform, and secure web-enabled portals for members and providers.

TruCare Cloud. We use TruCare Cloud, our member-centric health management platform for collaborative care and utilization management, to promote collaborative care that addresses the needs of members in an integrated manner for medical, BH, dental, and pharmacy. The platform enables real-time access to unified data from a variety of sources including eligibility, claims, care gaps, risk analysis, and non-medical risk factors to profile, measure, and monitor members, and identify the next best steps in the care management workflow. Care Managers can use TruCare Cloud to develop a single integrated plan of care in partnership with providers, displaying member health problems, treatment goals, milestone dates, and more. The plan of care is accessible to providers through the Provider Portal and to other community partners through the Community Partner Portal. State-specific clinical practice guidelines and evidence-based decision support criteria are integrated into the platform to assist Utilization Managers in managing prior authorizations, concurrent reviews, discharge planning, and transition service reviews. The integrated nature of TruCare Cloud ultimately results in more timely and informed care and authorization decisions, which lead to better health outcomes and improved member and provider experiences.

Centelligence reporting and analytics platform and Enterprise Data Warehouse (EDW). As noted above, our enterprise MIS supports whole-person care by integrating physical, BH, dental, pharmacy, and vision data into our EDW. This includes data such as health assessment, SDOH, utilization, and claims data. Powered by high-performance, cloud-based Teradata technology, the EDW supplies the data needed for all Centelligence analytic and reporting applications while orchestrating data interfaces among our core applications including TruCare Cloud, our Claims Processing Systems, secure Member, and Provider Portals, and other core MIS components. In addition, housing all information in Centelligence reporting and analytics platform allows Nebraska Total Care staff to design, test, and generate standard and ad hoc reports from a single data repository.

Secure Portals. We use secure portal technology to engage members and providers in coordinated, effective physical health and BH care.

- Our ***Member Portal*** is fully mobile-optimized, informed by user-friendly design, and offers members online access to their Nebraska Total Care physical and BH information. The Member Portal offers functions that promote whole-person health such as the ability to view integrated screenings and assessments, print temporary ID cards, and save them to their digital wallet. Members can also check the status of their rewards, promoting personal health care responsibility.
- Our ***Provider Portal*** supports physical and BH provider administrative self-service capabilities such as viewing their member panel, performing an eligibility inquiry, prior authorization submission, and status, claim submission and status, claim payment history, and a growing number of clinical applications, including online care gap notifications and health alerts, a member health record, patient analytics, and provider analytics. The individual member view offers an in-depth look at a member's clinical history as well as supporting documentation. Providers can also make online referrals of their patients for potential enrollment into a Nebraska Total Care's Care Management program.
- Our ***Community Partner Portal*** offers a secure portal for authorized users of 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 such as immunizations, allergies, and labs, other insurance information, plan of care, and can upload key documentation, and member assessments.

Effective Care Coordination for Members with Behavioral Health Needs / Integrated Care Model

Our integrated population health model is grounded in the principle that physical health, BH, and SDOH needs are wholly intertwined and need to be accessible to all Nebraskans. Through the combination of predictive analytics, claims history, and risk screenings/assessments, we fully capture members' health needs across the care continuum. For example, when we identify that a member is experiencing BH and substance use disorder (SUD) issues, we connect them to Care Coordination services that include person- and family-centered care planning, coordination of health and community services, medication reconciliation management, peer and family support, comprehensive discharge planning, and telehealth solutions. High-touch, person-centered Care Coordination is foundational to our support of members experiencing BH or SUD needs. We connect members to providers that offer integrated care and a continuum of co-occurring service options, such as Comprehensive Child and Family Treatment and Assertive Community Treatment (ACT) services. These services, provided by organizations like ***Centerpointe, Community Alliance, and South Central Behavioral Services***, offer members community-based intensive BH support and treatment.

Our integrated Care Management team fully engages with members' medical and BH providers during plans of care development and maintenance, which allows us to coordinate services and referrals more efficiently across settings. This includes Community Health Workers (CHWs) who will help members build ongoing relationships with primary care, outpatient specialty, BH, and community-based providers.

Member Services' Role in Coordinating Integrated Care Delivery. Our Member Service Representatives (MSRs) are trained on covered and non-covered services, Heritage Health programs, and referral processes for accessing necessary services. MSRs will continue to assist members with integrated care needs including:

- Selecting primary care or dental providers who can provide necessary specialized services such as Medication-Assisted Treatment (MAT)
- Identifying specialists to help manage a chronic health condition
- Identifying a BH provider who can meet cultural or linguistic needs
- Locating the closest pharmacy open on the weekend or late evenings
- Accessing community support resources, such as food banks and local transportation, to resolve unmet social needs
- Our HIDE SNP members have a dedicated member services line to specifically address any of their benefit needs or questions related to their HIDE SNP Medicare coverage.

Ensuring Access to Culturally Competent Care. In November 2021, we identified eleven-month-old Paisley as a member who would benefit from Care Management due to her complex medical conditions, including Down Syndrome. Nebraska Total Care Social Worker, Shawn, reached out to Paisley's mother, Crystal, who was also a current member. Using motivational interviewing, Shawn learned that Crystal had two other children and that Crystal had been a victim of domestic violence which led to the family experiencing homelessness over the last several months. Crystal felt extremely overwhelmed by additional life stressors and shared that her car had broken down, she had lost her job, her SNAP benefits had been reduced, and Paisley had recently been hospitalized multiple times. As the Housing Specialist at Nebraska Total Care, Shawn knew she had the resources to help Crystal and her family. Shawn connected Crystal with the Mod Rehab program which would only require Crystal to pay 30% of her monthly income towards rent. Shawn located a landlord that was willing to work with Crystal, provided Crystal with employment resources to help secure a new job, and helped her obtain a free cell phone through our Member Connections program. In February 2022, Crystal and her family were able to move into their new apartment. Shawn continued to support Crystal by helping her secure over $550 in donations from Nebraska organizations that allowed Crystal to purchase furniture, household goods, food, clothing, and toys for her children. Once Crystal and her family's immediate SDOH needs were addressed, Shawn partnered with a Nebraska Total Care physical health Care Manager to ensure Paisley would have access to ongoing support and care coordination for her complex medical needs.

17. Describe how the Bidder will train staff on issues that affect its members, including: issues related to housing, education, food, physical and sexual abuse, violence, food security; behavioral health risk and protective factors; finding community resources and making referrals to these agencies and other programs; and meeting the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns.

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Staff Training on SDOH, Community Resources, and LTSS

Since the inception of the Heritage Health contract in 2017, we have provided initial and ongoing training as needed to our staff and Subcontractors on issues that impact our members' physical and behavioral health, including Social Determinants of Health (SDOH), and finding community resources and making referrals to meet member needs. Our approach to care is based on a health equity framework designed to promote health for all members and address their needs, including social, behavioral, and environmental factors that impact an individual's overall health and well-being.

A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes; therefore, we will continue to educate and train all staff about issues related to housing, education, food, physical and sexual abuse, violence, food security, and behavioral health risk and protective factors and how they affect members' health and wellness. **Table 17.A Social Determinants of Health Training Curriculum for Nebraska Total Care Staff** provides descriptions of relevant initial and ongoing training courses that we will implement for the new contract.

Our parent company, Centene, and 14 of our Medicaid affiliates have experience serving the ***Long-Term Services and Supports (LTSS)*** population, including individuals with intellectual and developmental disabilities. Centene is the largest LTSS managed care payer in the country. Drawing from this expertise coupled with our local knowledge and experience in Nebraska, we will provide LTSS-related staff training as outlined in **Table 17.B Nebraska Total Care's Long-Term Services and Supports (LTSS) Training Curriculum**.

MLTC is welcome to attend any staff training and will be notified of training dates, times, and locations no less than 14 days before their occurrence. We are committed to continuing to provide a comprehensive training program that equips staff to meet the holistic needs of our members.

Methods for Educating and Training Staff. Staff training is offered through a variety of formats to meet the needs of various learning styles including in-person, remote, access to Learning Management Systems such as Centene University, hands-on, coaching, interactive online modules, employee newsletters, lunch and learn sessions with community agencies, and team meetings. During training, the staff is provided access to resources such as training manuals, policies and procedures, process flows, and a variety of other tools. As a best practice, training incorporate quizzes and assessments to measure training effectiveness and comprehension of content. We train all staff, at the time of hire and through required ongoing courses at regular intervals, on the major components of the Heritage Health programs, policies and procedures, contract, State, and requirements specific to each employee's job function.

All trainings are developed and conducted through a health equity lens and designed to support participants to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities.

Training on Social Determinants of Health (SDOH). Our initial and ongoing training for all staff includes programs focused on understanding SDOH and issues that impact members. To ensure staff is prepared to handle and respond to issues related to housing, education, food, physical and sexual abuse, violence, food security, and behavioral health risk and protective factors we will also deliver specialized training on SDOH to all member-facing teams as part of our functional area and role-based training.

The primary objectives of all SDOH training are to ensure staff:

- Understand what SDOH are and how they can impact overall health
- Recognize the potential that a member has for improved health outcomes when they are connected to resources that address social needs
- Know about the tools and processes we use to make closed-loop referrals to community resources that address SDOH

A selection of the SDOH Training Curriculum provided to Nebraska Total Care staff is listed below in **Table 17.A.**

Table 17.A. Social Determinants of Health Training Curriculum for Nebraska Total Care Staff

SDOH Content Area	Staff Training Description
Social Determinants in Action	This course provides an overview of housing, education, nutrition, physical and sexual abuse, violence, food security, transportation, employment, and BH risk and protective factors through a health equity lens. Trainees will learn to: • Explore each SDOH element and its link to health • Review real examples of health outcome consequences if needs go unmet • Discuss member stories about successful referrals to services • Detect and confirm social situations • Use empathic interpersonal approaches and strategies • Use motivational interviewing • Respond to and de-escalate conflict
SDOH Foundations	An online course presenting an overview to gain an understanding of SDOH with special attention given to the role of health disparities and health inequity, including steps that can be taken to address SDOH impacting members.
Meet Our Customers	Trainees will have a better understanding of our member population. • Explore a day in the life of a member through "a walk in their shoes" with a focus on SDOH elements
Cultural Sensitivity and Competence	Trainees will be able to: • Increase cultural awareness/worldview • Define culture / cultural competence • Discuss 5 levels of cultural competence • Identify barriers to culturally competent care • Identify how to incorporate cultural competency into daily work practices
Diversity Competencies: CLAS Standards	This course explores the ***National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*** principal standard: CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. Trainees will review how Nebraska Total Care uses CLAS standards to inform how we: • Provide ***culturally competent care*** for members including offering staffing and providers who reflect the population in the service area, • Offer ***language assistance*** services to members in their preferred language, verbally and in writing, and materials in languages commonly used by the population, • Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
Diversity Competencies: Poverty	This course explores the effect of ***poverty***. Trainees will be able to: • Understand the impact of poverty on members • Identify barriers to successful communication • Learn strategies to combat low health literacy • Understand how poverty may influence health care decision making
State of Nebraska Overview with a focus on SDOH	This training provides an overview of Nebraska's: • Health outcomes and disparities rankings by County include physical environmental elements such as water quality, social determinants such as education and employment, and other factors such as access to care, diet, and tobacco use. • Demographics and sociocultural diversity • Geography, culture (including regional similarities and differences), and distribution of the population and health care services • Prevalence of homelessness, rates of food insecurity, key transportation systems and gaps, rates of unemployment, rates of domestic violence disturbance reporting, and prevalence of prescription drug and illegal substances abuse

SDOH Content Area	Staff Training Description
SDOH Mini-Screen, Findhelp Community Resource Platform, and SDOH reporting tools	This training provides demonstrations of: • The ***SDOH Mini-Screen*** used to identify and address members' social needs using a seven-question assessment that takes two minutes or less. • How to use the ***Findhelp Community Resource Platform***, to find agencies and other programs for members. • ***SDOH reporting and analytics*** are used for search and referral data from ***Findhelp*** to monitor SDOH measures. Reporting and analytic tools give us detailed insights into specific member needs which we use to conduct outreach. It helps identify gaps in resources and the most prevalent needs of our membership.
Social Service Providers and Community Resources	This training provides an overview of: • Types of social services available and how to link members to them • Nebraska Total Care community partnerships and agencies by region • How to make referrals to help members
Unnatural Causes Training	Trainees watch videos independently and then participate in facilitated group discussions. • Unnatural Causes is the acclaimed documentary series that explores the root causes of our alarming socio-economic and racial inequities in health. • The series crisscrosses the nation uncovering startling new findings that suggest there is much more to our health than bad habits, health care, or unlucky genes. It emphasizes that the social circumstances in which we are born, live, and work, can get under our skin and disrupt our physiology as much as germs and viruses.
Trauma-Informed Care Across the Lifespan	Staff is trained to: • Define traumatic stress and adverse childhood experiences • Identify the four key elements of trauma-informed care • Understand the impact of trauma on health and well-being across the lifespan • Identify trauma-informed care practices for staff
The Wisdom of Trauma Training	Trainees watch the film *The Wisdom of Trauma Featuring Dr. Gabor Maté*, independently and then participate in facilitated group discussions. • In the film, Dr. Maté gives us a new vision: a trauma-informed society in which parents, teachers, physicians, policy-makers, and legal personnel are not concerned with fixing behaviors, making diagnoses, suppressing symptoms, and judging, but seek instead to understand the sources from which troubling behaviors and diseases spring in the wounded human soul. • The film explores trauma as an invisible force that shapes our lives and how it shapes the way we live, the way we love, the way we make sense of the world, and how it is the root of our deepest wounds.

Training Program Enhancements. In 2023, we will further expand SDOH training and education opportunities. We will offer continuing education units (CEUs) for clinical rounds and training via our CE Direct virtual platform with topic-specific opportunities for continuing education credits for all licensed staff. These include areas of SDOH, physical and sexual abuse, developmental disabilities, mental health issues, behavioral health risks, and protective factors. We have learned from experience that working with stakeholders as partners is critical to successfully impacting the members we serve. We will continue to work with and seek to partner with organizations and officials from Public Health Departments and Disability Advocacy groups to assist with staff training efforts. We will collaborate with organizations such as the University of Nebraska Medical Center's Munroe-Meyer Institute, the League of Humanity Dignity, and the Nebraska Disability Rights Center to provide input on our training curriculum and to participate in our staff training regularly.

How We Train Staff to Find Community Resources for Members and Make Closed-Loop Referrals. All staff is provided training about how we connect members to community resources, the types of agencies and programs we partner with, and the tools we use to do so, including calling the Nebraska Resource and Referral System (NRRS) by dialing 211 via telephone, and our community resource database, ***Findhelp***.

Our trainers provide demonstrations and have staff listen to and call the NRRS line to experience what a member would hear when they call. When anyone in Nebraska dials 211, they will hear a recorded announcement that explains they have

reached a service that can connect them with an agency for help with free and confidential information and referral for help with food, housing, employment, health care, counseling, and more, and can choose to be connected to a Community Specialist for live help.

Findhelp Platform. 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. Findhelp is a searchable, vetted, and regularly updated database of current health and wellness resources, including all of Nebraska and border towns like ***Council Bluffs, Rapid City, Denver, and Sioux City***. Findhelp helps staff connect members to local programs and resources that best fit their needs, including, housing, transportation, food banks, job opportunities, BH services, and more.

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, emotional, and PH resources.

Staff training on how to use Findhelp includes:

- A demonstration of how to access and register as a user on the Findhelp.org website
- Examples of how to connect to local support for food, housing, transit, financial assistance, education, employment, legal services, or other free or reduced-cost services
- Live scenarios of real member situations
- A question-and-answer discussion

Staff who have direct contact with members, such as our Care Managers, Community Health Workers (CHWs), and Member Service Representatives (MSRs), are provided in-depth training on how to help members identify community resources and refer them to the most appropriate programs for their needs. Staff is trained to administer our SDOH Mini-Screen, explained in detail in our response to Question V.N.54 of this proposal, to identify members' social needs. If a member completes the seven-question Mini-Screen or presents as in need of a referral to community resources, staff will use the Findhelp platform to find the right agency or program to help or refer the member to the site.

We train staff to recognize and help members with cognitive impairment or limited communication skills, limited English proficiency (LEP), financial stress, SDOH needs and connecting to resources, and general issues or problems they may be having. For instance, if an MSR hears that a member has SDOH needs, they can conduct the SDOH Mini-Screen and provide available resources and information about where to get services using our Findhelp platform.

Nebraska Total Care's Community Partner Portal. Staff training on our secure Community Partner Portal will include a live demonstration from a trainer followed by staff using the portal and asking questions about how to find or input data based on sample member scenarios. Our ***Community Partner Portal*** offers a secure method 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 plans of care, and can upload key documentation, member assessments, and free text and structured notes.

Our training curriculum ensures that our staff and our provider partners that interface with members are well-positioned to provide assistance and facilitate access to community resources and services, including LTSS delivered under fee-for-service. As we add community resources to our database, we conduct refresher training and continue working with local stakeholders to expand our offering of training courses, led by external local stakeholders, well versed in the needs and rights of individuals in Nebraska with disabilities.

Meeting the Needs of the LTSS Population – Training Curriculum. We will use our Long-Term Services and Supports (LTSS) Training curriculum to ensure staff is prepared to meet the needs of the LTSS population, including individuals with intellectual and developmental disabilities and mental health concerns. **Table 17.B Nebraska Total Care's LTSS Training Curriculum** provides excerpts from our comprehensive training program. All training listed in the table will be provided as part of our initial-hire orientation, and some will be offered annually, and as needed. Training can be customized in response to any contract updates, changes, or community needs.

All Nebraska Total Care staff receive LTSS-related training via multiple modalities during required initial hire and ongoing staff education sessions. Additionally, our Disability Liaison will provide new hire orientation and ongoing training on Disability and Waiver services for our Utilization Management and Care Managers to enhance the skillsets of teams that coordinate clinical care for members with intellectual and developmental disabilities. Our Disability Liaison, Joni Thomas, has a wealth of knowledge about how members qualify and apply for long-term care or disability programs within the State

and will continue to serve as a valuable resource to meet the needs of our LTSS population.

Table 17.B Nebraska Total Care's LTSS Training Curriculum

LTSS Content Area	Key Topics Presented in Staff Training
Heritage Health and LTSS	• Heritage Health program overview and eligible populations • Long-Term Services and Supports (LTSS) eligibility requirements • Covered benefits and services • Collaboration with local agencies
LTSS 101	• Long Term Care (LTC) eligibility and enrollment overview • LTC benefits overview, including HCBS waiver services and providers • Independence and self-direction • Activities of Daily Living • How to access LTSS for Heritage Health members • Nebraska Total Care's role in the coordination of LTSS services and other carved-out benefits • Aging Support and Education • Disability Awareness and Sensitivity • Case studies
Profile and characteristics of the LTSS population	• Age, gender, income, education levels • Profile and characteristics of the LTSS population • Residential settings for the LTSS population
Intellectual and Developmental Disability (I/DD) System Overview	• Guardianship rights • Political developments past, present, and future • Parallels between the Service Delivery System and the Civil Rights Movement: Discussion of political changes and Federal requirements in response to the treatment of people with I/DD • The evolution of the managed care movement – discussion of the funding system and covered benefits and services both Federally and locally.
Approach to Services for I/DD population and individuals with disabilities	• Best practices and case studies • Social role of people with I/DD in the community • People First Language • Learning the person's language: how to approach people who are categorized as non-verbal or behaviorally complex • Identifying the needs of members and finding ways to help • Nutrition and well-being • Polypharmacy • Discharge planning and coordination

The 5 Pathways of Service Delivery	• Overview of the 5 pathways and visions for an integrated life for LTSS
	  ○ Behavioral, medical, employment, residential, and member-directed services
	  ○ How to determine if an individual requires support in a particular area
	• Discussion of questions that can be asked to determine if a presenting issue is a behavioral, medical, or related to another Pathway such as employment
	• Solutions to address the needs of the individual based on the individual's presenting symptoms
	• Overview of the teams with members who may use a different approach and proper facilitation practices to implement the approach to services

Michael Smull Person-Centered Training	• Overview of person-centered thinking and planning: Its purpose is to promote the use of person-centered practices among people with disabilities and older adults, their families, and supporters, to create positive change in their own lives, communities, and organizations. • Demonstration and discussion of the Person-Centered Planning as a guided process for learning how someone wants to live at home, at work, and in the community and for developing a plan to help make it happen.

Training for Subcontractors

Subcontractors that perform delegated services for members will complete our required new employee orientation and computer-based training courses as a part of initial training. They will also complete ongoing training with Nebraska Total Care as needed for job-specific knowledge and compliance. All training programs must adhere to Nebraska Total Care contractual, MLTC, and State and Federal requirements. Both the employee orientation and ongoing training will include training on SDOH and meeting the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns.

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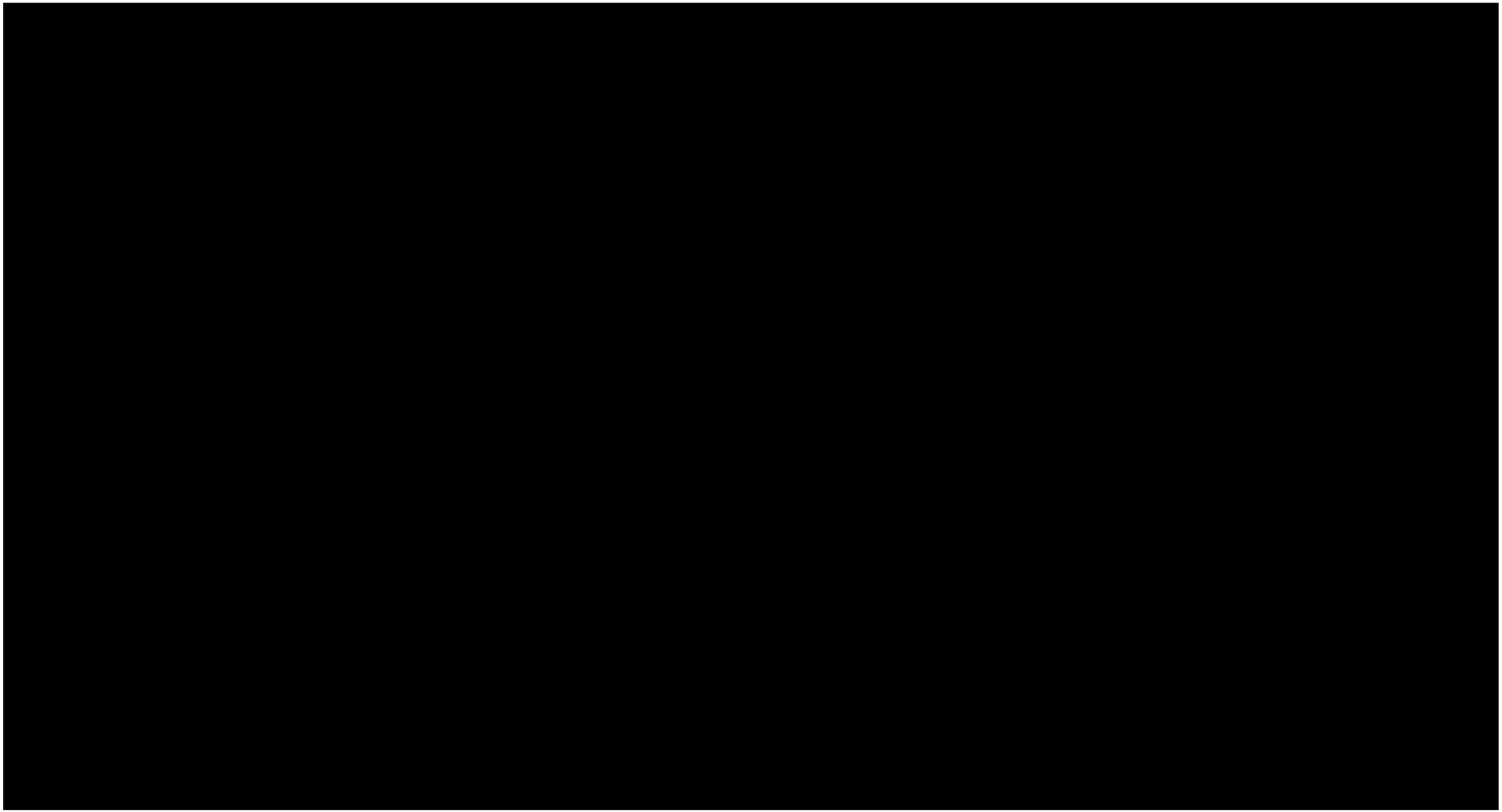
Attachment B.12

Nebraska Total Care's Corporate Structure Organizational Chart



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Attachment B.13

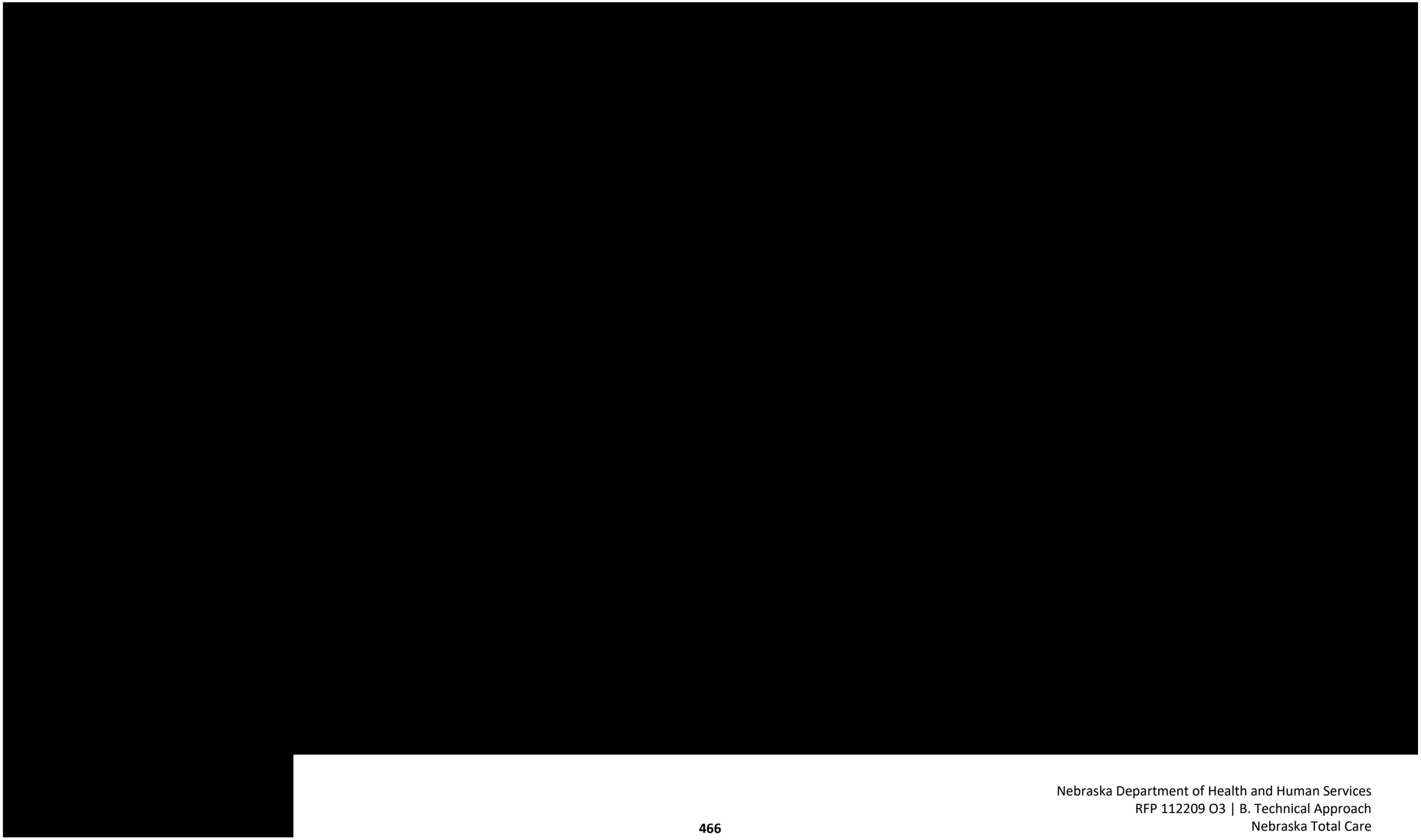
Nebraska Total Care Organizational Charts

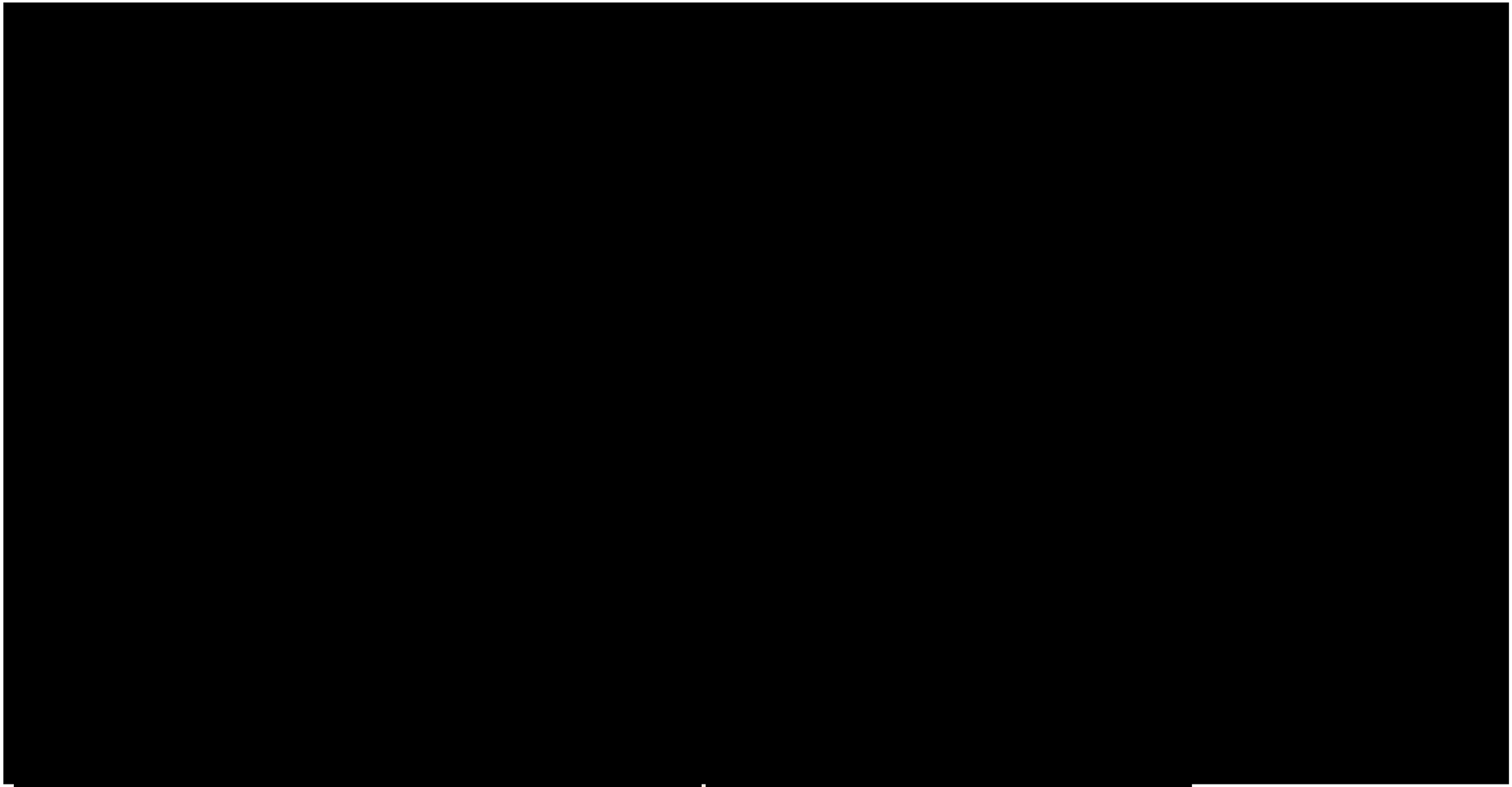
Chart A - Nebraska Total Care Overview

Chart B - Population Health and Clinical Operations Including Dental, Care Management, Utilization Management, and Behavioral Health

Chart C - Quality and Pharmacy

Chart D - Operations, Compliance, and Finance





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Attachment B.15
Job Descriptions

Job Description

State Position Title: Chief Executive Officer (CEO)
Health Plan Position Title: Plan President & Chief Executive Officer (CEO)
Reporting Relationship: Nebraska Total Care Board of Directors

Position Purpose

Provides overall direction and prioritization for Nebraska Total Care. Plans and directs all aspects of the organization's operational policies, objectives, and initiatives, including achievement of Division of Medicaid and Long-Term Care (MLTC) Program goals.

Education/Experience

Bachelor's degree in health care administration, public administration, business, or related field; master's degree preferred. Five or more years of experience in a top management position in the government or healthcare industry. Extensive experience in contracting, contract acquisition, operations management, and strategic planning and development. Previous experience managing staff, including hiring, training, managing workload and performance. Experience working with Medicaid populations is required. Position is based in Nebraska.

License/Certificates

N/A

Position Responsibilities

- Provide overall direction and prioritization for Nebraska Total Care; determine a sound short- and long-range plan for the organization
- Must work full-time on the contract, a minimum of 40 hours per week
- Develop and carry out leadership strategies
- Oversee the development of all operating policies and procedures; and ensure compliance with established standards, regulations and that MLTC contractual requirements are followed
- Provide operational oversight to ensure MLTC Program and Nebraska Total Care goals are achieved
- Develop and implement integration models that ensure coordination with system partners
- Represent Nebraska Total Care in its relationships with other Managed Care Organizations (MCOs), major subcontractors, commercial and investment bankers, government agencies, professional societies, and similar groups
- Participate in MLTC business reviews
- Ensure the adequacy and soundness of the organization's financial structure and systems, and review projections of working capital requirements
- Negotiate and otherwise arrange for any outside financing that may be indicated

Job Description

State Position Title: Medical Director / Chief Medical Officer (CMO)
Health Plan Position Title: Chief Medical Officer
Reporting Relationship: Chief Executive Officer

Position Purpose

Direct and coordinate the Quality Management (QM), Population Health, Utilization Management (UM), Care Management, Disease Management, and Provider Credentialing functions for Nebraska Total Care based on, and in support of, the strategic plan. Establish the strategic vision and attendant policies and procedures.

Education/Experience

Medical Doctor or Doctor of Osteopathy, currently practicing, with a minimum three years of training in a medical specialty and five years of clinical practice. Volunteer patient care and experience working with Medicaid populations is required. Previous experience as a Medical Director is preferred. Master's degree in business administration, public health, health care administration, or related field preferred. Position is based in Nebraska.

Licenses/Certifications

Board certified in their specialty, recognized by the American Board of Medical Specialists. Current unrestricted Nebraska medical license.

Position Responsibilities

- Develops, implements, and interprets medical policies and procedures, including those for service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals
- Administers medical management activities, advising clinical staff, addressing regulatory accreditation concerns, participating in audits and corrective action plans, and facilitating the achievement of population health goals through an effective health services delivery system
- Participates at every quality meeting with MLTC and other system partners, and as requested by MLTC
- Devotes a minimum of 40 hours per week to Nebraska Total Care operations to ensure timely medical decisions, including after-hours consultation as needed
- Is actively involved in all major clinical, UM, and QM decisions
- Chairs the Quality Assessment and Performance Improvement (QAPI) and Clinical Advisory Committees, as well as leading other quality committees such as the UM, Provider Advisory, and Provider Credentialing Committees
- Oversees internal medical review guidelines to ensure clinical integrity and compliance and acts as a resource for staff members throughout the operation
- Performs medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services
- Responsible for physician review and oversight of all potential adverse determinations including pre-certifications/prior authorizations, concurrent review, and appeals/retrospective review
- Responsible for HEDIS improvement and strategy
- Achieves utilization, cost management, and quality goals
- Participates and advises in the development of corporate medical policies for UM, pharmacy, and new technology

Job Description

State Position Title: Dental Director
Health Plan Position Title: Dental Director
Reporting Relationship: Chief Medical Officer

Position Purpose

Responsible for the administration and delivery of all dental services provided by Nebraska Total Care, including policy development and clinical performance direction and oversight for the Dental Benefit Manager (DBM). The position works with the DBM to identify provider network needs and develop strategies to fill identified gaps and ensure an appropriate training process is in place for all providers. The Dental Director is responsible for the coordination and monitoring of dental continuous quality improvement activities.

Education/Experience

Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree from a university-based dental education program accredited by the American Dental Association Commission on Dental Accreditation. Ten or more years of clinical dental practice experience, including three or more years of experience in insurance or benefits administration setting. Experience and expertise working with the Medicaid population required.

License/Certificates

Current unrestricted license as a Doctor of Dentistry ("dentist") in the state of Nebraska.

Position Responsibilities

- Oversee dental activities and ensure compliance with applicable federal and state statutes and regulations
- Available Monday through Friday, between 8 a.m. and 5 p.m. Central Time for utilization review decisions, and is authorized and empowered to represent the Dental Benefit Manager (DBM) regarding clinical issues, utilization review, and quality-of-care (QOC) inquiries
- Formulate all decisions to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested
- Work in conjunction with the DBM to identify provider network needs and develop strategies to fill identified gaps
- Share oversight with the DBM for dental provider orientation, education, and in-service training
- Continuously assess and improve of the quality of dental care provided to members
- Serve as a liaison with local regulatory agencies and dental community
- Collaborate with senior leadership to provide current dental expertise and direction for the dental program
- Provide dental advice to health committees and attend required meetings or functions as requested
- Chair or co-chair the Dental Quality Assessment and Process Improvement Committee (QAPIC)
- Directs the Dental Utilization Management Committee
- Ensure DBM utilization review activities conform to company protocols, state requirements, and professional standards
- Provide dental clinical expertise to resolve complex and/or unique administrative circumstances
- Provide expert dental education and consultation for the clinical staff as needed
- Work with care management and quality management to interpret multiple data sources and identify trends in dental utilization
- Work with the DBM as needed to review provider and member complaints, assist in resolution, and make recommendations

Job Description

State Position Title: Dental Management Coordinator
Health Plan Position Title: Dental Management Coordinator
Reporting Relationship: Dental Director

Position Purpose

Administer, maintain, and implement utilization and quality management activities, which include the review of prior authorizations, clinical appeals, and potential quality issues. Provide dental advice and counsel to internal and external customers as needed.

Education/Experience

Doctor of Dental Surgery (DDS) or Dental Medicine (DMD) degree from a university-based dental education program accredited by the American Dental Association Commission on Dental Accreditation. Seven or more years of clinical dental practice, including three or more years of experience in claims review or consulting. Experience and expertise working with the Medicaid population required.

License/Certificates

Current unrestricted license as a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) in the state of Nebraska.

Position Responsibilities

- Develop, implement, and monitor the provision of care coordination, disease management (DM), and case management functions
- Ensure the adoption and consistent application of appropriate dental services medical necessity criteria
- Monitor, analyze, and implement appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services
- Monitor prior authorization functions and ensure that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards
- Oversight of inpatient concurrent review
- Review, administer, and maintain prior and retrospective authorizations and clinical appeals
- Actively participate in the functioning of Nebraska Total Care grievance procedures for the dental plan
- Resolve grievances related to dental quality of care (QOC) under the dental plan
- Direct the implementation of quality improvement activities under the dental plan, including tracking and trending QOC issues
- Ensure clinical decisions are not influenced by fiscal or administrative management considerations
- Evaluate dental care provided to ensure it meets state clinical criteria and standards for acceptable dental care and ensure dental protocols are followed
- Assist in the design, development, and implementation of appropriate dental policies, protocols, and procedures which comply with the most current accepted professional standards
- Actively participate in the functioning of the program integrity protocols of the dental plan
- Responsible for dental consultant training and calibration
- Primary dental clinical contact for UM, claims, and Provider Relations personnel

Job Description

State Position Title: Behavioral Health Clinical Director
Health Plan Position Title: Behavioral Health Medical Director
Reporting Relationship: Chief Executive Officer

Position Purpose

Oversight and responsibility for all behavioral health (BH) clinical programs and activities. Assist the Chief Medical Officer (CMO) to direct and coordinate the Population Health, Utilization Management (UM), Quality Management (QM), and Provider Credentialing functions for Nebraska Total Care.

Education/Experience

Medical Doctor or Doctor of Osteopathy. Minimum of five years of combined clinical experience in mental health and substance use disorder services and is knowledgeable about primary care/BH integration. Seven or more years of clinical experience in the practice of medicine. UM experience and knowledge of quality accreditation standards preferred. Actively practices medicine. Course work in the areas of health administration, health financing, insurance, and/or personnel management is advantageous. Experience treating or managing care for a culturally diverse population preferred. Experience and expertise working with the Medicaid population required.

Licenses/Certifications

Board certification by the American Board of Psychiatry and Neurology. Must be a currently practicing psychiatrist or psychologist with an unrestricted license in the state.

Position Responsibilities

- Provide clinical case management consultations and clinical guidance for contracted primary care providers (PCPs) treating BH-related concerns not requiring referral to BH specialists
- Develop comprehensive care management programs for youth and adults with BH concerns, typically treated by PCPs, such as Attention Deficit Hyperactivity Disorder (ADHD) and depression
- Develop education and training for Nebraska Total Care's PCPs who commonly encounter BH issues
- Provide BH expertise to population health, UM, and QM functions and take an active role in clinical and policy decisions
- Provide medical leadership for UM, cost containment, and quality improvement activities in accordance with regulatory, state, and accreditation requirements
- Perform medical review activities, including utilization review, quality assurance, and claims reviews to determine medical necessity and appropriate payment for complex, controversial, or new services
- Assist CMO to develop goals and policies that improve quality and cost-effectiveness of member care
- Assist the CMO in managing the structure, processes, and membership of physician committees
- Oversee physician advisors and use medical and pharmacy consultants to review complex cases and medical necessity appeals
- Evaluate adverse trends in utilization of medical services, unusual provider practice patterns, and adequacy of benefit/payment components; identify clinical quality improvement studies to assist providers in reducing unwarranted variation in clinical practice to improve the quality and cost of care; assist in the development and implementation provider education regarding clinical issues and policies
- Develop alliances with the provider community through the development and implementation of the population health programs

Job Description

State Position Title: Behavioral Health Manager
Health Plan Position Title: Manager, Behavioral Health
Reporting Relationship: Behavioral Health Clinical Director

Position Purpose

Position is responsible for ensuring that Nebraska Total Care behavioral health (BH) operations, including the operations of BH subcontractors, comply with contract requirements.

Education/Experience

Bachelor's degree in social services, psychology, health administration, or related field. Master's degree in a behavioral health specialty preferred. Five or more years of related experience. Working knowledge of Medicare, Medicaid, and health plan administration. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work, and managing the performance of staff. Experience working with Medicaid populations is required. Position is based in Nebraska.

Licenses/Certifications

Licensed in the state of Nebraska as a behavioral health professional, such as a psychologist (PhD), psychiatrist (MD), social worker (LCSW), psychiatric nurse (RN), marriage and family therapist (LMFT), or mental health counselor (i.e., LPC).

Position Responsibilities

- Ensures that BH operations, providers, and any subcontractors comply with Contract requirements
- Coordinates with all areas of the health plan, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting
- Participates in all quality management and improvement activities, including the Behavioral Health Advisory Committee and other quality committees to facilitate BH integration across the delivery system
- Works closely with MCO network development and provider relations staff to develop and maintain the BH network and ensure that it is fully integrated with the physical health provider network
- Partners with UM staff to monitor BH utilization, especially to identify and address potential BH under- or over-utilization
- Acts as primary liaison with BH community resources, including Community Mental Health Centers (CMHCs)
- Responsible for all reporting related to the provision of BH services
- Oversees subcontracts for BH services

Job Description

State Position Title: Chief Operating Officer
Health Plan Position Title: Senior Vice President, Operations
Reporting Relationship: Chief Executive Officer

Position Purpose

Oversee all health plan operations, procurement opportunities, new product implementations, and complex initiatives for business development utilizing cross-functional business units and corporate teams to meet business unit and corporate strategic objectives.

Education/Experience

Bachelor's degree in business administration, finance, accounting, or a related field. Ten or more years of operations, management, or administration in the health care or insurance industry. Experience in business development and/or request for proposal (RFP) experience. Extensive knowledge of state legislative and regulatory processes. Master's degree preferred. Experience and expertise working with the Medicaid population is required. Position is based in Nebraska.

Position Responsibilities

- Manage the day-to-day operations of Nebraska Total Care's departments, staff, and functions to ensure that performance measures and MLTC and federal requirements are met
- Serve as the primary contact with MLTC for all health plan operational issues
- Partner with multiple stakeholders and business unit leadership to establish strategic visions, operational objectives, and policies and procedures ensuring compliance with state contracts, related laws, regulations, and executive orders
- Develop, execute, and communicate to all stakeholders the annual plans for membership growth initiatives
- Develop and implement key metrics and performance standards across the organization to review past, current, and future performance of business unit
- Monitor and report on achievement of committed action plans to senior management
- Direct the development and implementation of operational work processes and systems with oversight for multiple departments within the business unit, including call center operational services
- Oversee operational budget, revenue targets, and profit and loss
- Lead and oversee new business implementation and reprocurement activities for all products and complex projects, including RFP responses
- Evaluate program opportunities and recommendations for effectiveness and return on investment (ROI)
- Perform duties as senior liaison between the business unit, corporate, and external stakeholders
- Oversee preliminary discovery, due diligence for potential liabilities, internal control weaknesses, and financial integrity

Job Description

State Position Title: Chief Financial Officer
Health Plan Position Title: Chief Financial Officer
Reporting Relationship: Chief Executive Officer

Position Purpose

Provide leadership and oversight of all aspects of finance for Nebraska Total Care.

Education/Experience

Bachelor's degree in finance, accounting, economics, or business administration. Ten or more years in a high-level finance role in the health care or insurance industry. Master's degree preferred. Experience and expertise working with the Medicaid population is required. Position is based in Nebraska.

License/Certificates

Certified Public Accountant (CPA) preferred.

Position Responsibilities

- Oversee all finance activities for Nebraska Total Care, including all audit activities, accounting systems, financial reporting, budgeting, and developing and monitoring progress against the annual operating plan
- Approve submission of truthful, accurate, and complete encounter data
- Responsible for financial analysis, identification of month-end financial drivers, and forecasting, including headcount planning to ensure compliance with state requirements
- Responsible for identifying medical cost trends and leadership of medical cost improvement initiatives
- Perform financial impact analysis for new contracts and support negotiations
- Review monthly performance and financial results and provide recommendations to senior management
- Responsible for Nebraska Total Care's contribution to corporate
- Perform duties as chief liaison between Corporate Finance and Nebraska Total Care
- Establish financial strategic vision, objectives, policies, and procedures in support of the overall strategic plan
- Oversee and validate pricing models and lead initiatives to identify inefficiencies and areas of development and improvement
- Direct Nebraska Total Care's analytical needs and coordinate reporting strategy
- Act as a lead for internal and external audits
- Lead rate setting activity and coordinate corporate and state actuaries

Job Description

State Position Title: Program Integrity Officer
Health Plan Position Title: Vice President, Compliance
Reporting Relationship: Chief Executive Officer

Position Purpose

Ensure regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and its business subsidiaries.

Education/Experience

Bachelor's degree in public policy, government affairs, business administration, or related field. Eight or more years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations, including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third-Party Administration (TPA) laws, credentialing regulations, and prompt pay laws. Master's or law degree preferred. Experience in health care and/or risk management required. Experience and expertise working with the Medicaid population required. Position is based in Nebraska.

License/Certificates

N/A

Position Responsibilities

- Ensure Nebraska Total Care and Centene Corporate compliance with state and federal program regulations, insurance regulations, regulatory requirements for business entities, and state contract requirements
- Oversee all activities required by state and federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse (FWA), and erroneous payment compliance program
- Develop and oversee methods to prevent and detect potential FWA and erroneous payments
- Develop policies and procedures, investigate unusual incidents, and design and implement corrective action plans
- Review records and refer suspected member FWA to MLTC and other duly authorized enforcement agencies
- Manage the Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit
- Serve as the primary point of contact for MLTC Program Integrity and confidential reporting of plan violations
- Maintain and track laws and regulations, contract documentations, amendments, and compliance measures
- Oversee, administer, and implement various compliance programs, including FWA and HIPAA
- Provide guidance to various departments regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language
- Conduct compliance audits, develop and implement corrective action plans, and report on achievement of action plans to senior management and board of directors
- Develop strategic relationships with state legislative policymakers and assist with the development of state legislative public policy concerning state insurance, Managed Care Organizations, Medicare and Medicaid regulations and initiatives
- Identify, evaluate, and analyze the impact of state legislative and regulatory issues and advise management concerning impact
- Represent senior management at various committees, meetings, and seminars

Job Description

State Position Title: Grievance System Manager
Health Plan Position Title: Manager, Grievance and Appeals
Reporting Relationship: Chief Operating Officer

Position Purpose

Ensure appropriate processing of member and provider grievances and appeals, and member requests for a State Fair Hearing. Perform duties as the point of contact with the state. Manage the day-to-day responsibilities of the Grievance and Appeals Coordinators.

Education/Experience

Bachelor's degree in related field or equivalent experience. Three or more years of experience in health care, law, or grievances and appeals. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work, and managing the performance of staff. Experience and expertise working with the Medicaid population required. Position is based in Nebraska.

License/Certificates

N/A

Position Responsibilities

- Ensure that the grievance and appeals department processes all appeals and grievances in accordance with referred time frames and other contractual legal requirements
- Monitor appeals and grievances and provide senior management with monthly reporting on trends
- Ensure that all member and provider grievances are processed and investigated according to contract requirements
- Work with various external constituencies, i.e., state, local and federal governments, local community, and the public related to grievance and appeals
- Integrate federal and state law changes into health plan's regulatory system related to grievance and appeals
- Recommend solutions and work with health plan staff to ensure problems are corrected and departments are advised of corrective measures to prevent recurrences
- May provide training and direction to agencies in developing procedures to comply with grievance and appeals requirements
- Review and process incoming incident/accident reports

Job Description

State Position Title: Business Continuity Planning and Emergency Coordinator
Health Plan Position Title: Manager, Compliance
Reporting Relationship: Contract Compliance Officer

Position Purpose

Manage and oversee Nebraska Total Care's emergency management plan and ensure continuity of benefits and services for members in the event of a disaster. Manage the compliance department functions, including but not limited to, periodic monitoring and auditing activities based on established compliance program, policies, and practices to ensure and maintain compliance with federal, state, and local regulatory, contractual, and legal requirements.

Education/Experience

Bachelor's degree in health care administration, compliance, or related field or equivalent experience. Business Continuity Planning degree preferred. Four to six years of compliance experience, including risk assessment against contract and regulatory requirements; creation and execution of auditing; monitoring and reporting processes; administration of correction action plans; implementation of written policies and procedures; and developing and delivering compliance training and education. Managed health and/or behavioral health experience preferred. Experience and expertise working with the Medicaid population required.

License/Certificates

N/A

Position Responsibilities

- Ensure continuity of benefits and services for members who may experience evacuation to other areas of the state, or out-of-state, during disasters
- Manage and oversee Nebraska Total Care's emergency management plan
- Manage approval and submission of timely and accurate contract and regulatory required report deliverables
- Oversee all contracts updates including creating new and updating existing contracts with health plans, states, and consultants/vendors
- Conduct periodic assessments to ensure compliance against contract requirements
- Oversee creation and implementation of corrective action plans to reduce or eliminate risk resulting from non-compliance with contract requirements or performance deficiencies
- Collaborate with health plans and states, where applicable, to maintain/improve customer satisfaction specific to delegated functions and compliance with contract requirement.
- Manage submission of consumer and provider communication materials, including participation in their review and timely submission to health plans and states, where applicable
- Manage composition and delivery of responses to state regulatory agency complaints and inquiries
- Determine licensure requirements and administration of ongoing licensure maintenance, including research in new markets and timely filing for recurring deliverables, such as licensure renewals
- Support responses to request for proposals (RFPs) and new business implementations by completing assigned compliance tasks timely and accurately
- Participate in new business implementations, including the identification and tracking of required contract report deliverables as well as new reporting and provider/member materials
- Design, implement, and improve processes to prevent, detect, and respond to compliance issues and concerns related to all federal and state regulatory requirements and contract requirements
- Create and deliver compliance training for all employees on an annual basis and as needed basis, such as in response to a compliance issue or concern

Job Description

State Position Title: Contract Compliance Officer
Health Plan Position Title: Vice President, Compliance
Reporting Relationship: Chief Executive Officer

Position Purpose

Ensure regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and its business subsidiaries.

Education/Experience

Bachelor's degree in public policy, government affairs, business administration, or related field. Eight or more years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third-Party Administration (TPA) laws, credentialing regulations, and prompt pay laws. Master's or law degree preferred. Experience and expertise working with the Medicaid population required. Position is based in Nebraska.

License/Certificates

N/A

Position Responsibilities

- Ensure Nebraska Total Care and Centene Corporate compliance with state and federal program regulations, insurance regulations, regulatory requirements for business entities, and state contract requirements
- Serve as the primary contact with MLTC on all contract compliance issues and confidential reporting of plan violations
- Oversee all activities required by the contract, state and federal rules and regulations related to the coordination, preparation, and execution of contract requirements
- Coordinate the tracking and submission of all contract deliverables and answer inquiries from MLTC
- Coordinate/perform random and periodic audits and ad hoc visits
- Maintain and track laws and regulations, contract documentations, amendments, and various compliance measures
- Develop policies, procedures, and processes to comply with state law, federal law, contract requirements, and various standards
- Oversee, administer, and implement various compliance programs, including fraud and abuse and HIPAA
- Provide guidance to various departments regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language
- Conduct compliance audits, develop and implement corrective action plans, and report on achievement of action plans to senior management and board of directors
- Develop strategic relationships with state legislative policymakers and assist with the development of state legislative public policy concerning state insurance, Managed Care Organizations, Medicare and Medicaid regulations and initiatives
- Identify, evaluate, and analyze the impact of state legislative and regulatory issues and advise management concerning impact
- Represent senior management at various committees, meetings, and seminars

Job Description

State Position Title: Quality Management Coordinator
Health Plan Position Title: Vice President, Quality and Process Improvement
Reporting Relationship: Chief Executive Officer

Position Purpose

Develop and oversee quality improvement programs and strategies for Nebraska Total Care. Assist in the development and application of Nebraska Total Care's strategic mission and vision. Identify and champion the selection of process improvement activities across the enterprise.

Education/Experience

Bachelor's degree in health care or related clinical field. Master's in Business Administration preferred. A minimum of ten years of health care operations experience including quality management and process improvement. Experience with NCQA accreditation preparation and auditing, including the analysis of HEDIS performance measures. Experience working with Medicaid population required. Position is based in Nebraska.

Licenses/Certifications

Must be a state-licensed registered nurse, physician, or physician's assistant; a Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality; or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers.

Position Responsibilities

- Ensure systemic and individual quality of care
- Identify and implement process improvements
- Integrate quality throughout the organization
- Ensure a network of credentialed providers
- Resolve, track, and trend quality of care grievances
- Serve as a member of the Quality Assessment Performance Improvement (QAPI) Committee and as a member/ad hoc member of other quality related committees
- Drive performance improvement for HEDIS, State Contract Quality, and Pay for Performance/Withhold, quality metrics and processes, and other quality improvement opportunities as needed
- Develop infrastructure and processes for management of activities related to National Committee for Quality Assurance (NCQA) Accreditation and Healthcare Effectiveness Data and Information Set (HEDIS) performance ensuring highest level of accreditation
- Identify and implement enterprise wide and market specific process improvement programs
- Review and present results of quality interventions for clinical and operational performance improvements and identify organizational risks to executive management
- Develop and ensure consistent, reliable, and valid application of data collection and analysis for priority performance measures, including HEDIS, pay for performance and contractual performance measures
- Review cost benefit and return on investment analyses for organizational resource allocation and recommend action plans
- Build relationships and position Nebraska Total Care as the "go to" source for MCO Quality Metrics

Job Description

State Position Title: Performance and Quality Improvement Coordinator
Health Plan Position Title: Data Analyst IV, Quality Improvement
Reporting Relationship: Quality Management Coordinator

Position Purpose

Develop and oversee quality improvement programs and strategies for Nebraska Total Care. Assist in the development and application of Nebraska Total Care's strategic mission and vision. Identify and champion the selection of process improvement activities across the enterprise.

Education/Experience

Bachelor's degree in healthcare or related clinical field. Master's in Business Administration preferred. A minimum of ten years of healthcare operations experience including quality management and process improvement. Experience with NCQA accreditation preparation and auditing, including the analysis of HEDIS performance measures. Experience working with Medicaid population required. Position is based in Nebraska.

Licenses/Certifications

Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers preferred. RN License preferred.

Position Responsibilities

- Serve as the Division of Medicaid and Long-Term Care's (MLTC's) contact person for quality performance measures and report quality improvement and performance outcomes to MLTC
- Drive organizational efforts to improve clinical quality performance measures, including HEDIS, State Contract Quality and Pay for Performance/Withhold, quality metrics and processes, and other quality improvement opportunities as needed
- Serve as a member of the Quality Assessment Performance Improvement (QAPI) Committee
- Develop infrastructure and processes for management of activities related to National Committee for Quality Assurance (NCQA) Accreditation and Healthcare Effectiveness Data and Information Set (HEDIS) performance ensuring highest level of accreditation
- Develop and implement enterprise wide and market specific process improvement programs and process improvement projects across MCOs; use data to develop intervention strategies to improve outcomes
- Review and present results of quality interventions for clinical and operational performance improvements and identify organizational risks to executive management
- Develop and ensure consistent, reliable, and valid application of data collection and analysis for priority performance measures, including HEDIS, pay for performance, and contractual performance measures
- Review and analyze cost benefit and return on investment analyses for organizational resource allocation and recommend action plans
- Responsible for building relationships and positioning Nebraska Total Care as the "go to" source for state-of-the-art MCO Quality Metrics

Job Description

State Position Title: Maternal Child Health (MCH) / Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator
Health Plan Position Title: Senior Manager, Quality Improvement
Reporting Relationship: Quality Management Coordinator

Position Purpose

Provide leadership and direction for continuous quality improvement (QI) initiatives to improve efficiency, processes and demonstrate improved quality. Provide and analyze reports to identify trends, opportunities and recommend initiatives aimed at improving quality of care and services provided by the organization.

Education/Experience

Must be a current, Nebraska-licensed registered nurse, physician, or physician's assistant; have a master's degree in health services, public health, health care administration, or related field; or be a Certified Professional in Health Care Quality (CPHQ) or Certified in Health Care Quality and Management (CHCQM).

Bachelor's degree in Business, Healthcare, or related field. Master's degree preferred. A minimum of five years of quality management experience or equivalent leadership experience. Previous experience as lead in functional area, managing cross functional teams on large scale projects or supervisory experience which includes hiring, training, assigning work and managing the performance of staff. Experience working with Medicaid population required. Position is based in Nebraska.

Licenses/Certifications

Current, unrestricted license to practice in Nebraska as a nurse, physician, or physician's assistant, preferred. CPHQ by the National Association for Health Care Quality or CHCQM by the American Board of Quality Assurance and Utilization Review Providers, preferred.

Position Responsibilities

- Design programs to ensure that all member children receive necessary EPSDT services
- Promote family planning services and preventive health strategies
- Promote preventive health strategies
- Design programs to ensure that all pregnant members receive maternal and postpartum care
- Identify and coordinate assistance to address member needs specific to MCH and EPSDT
- Interface with community partners to improve quality and utilization of MCH and EPSDT services
- Work with the Medical Management Coordinator and Care Management Staff to provide comprehensive care and case management for members in the 599 CHIP program
- Oversee accreditation process, specifically as it pertains to National Committee for Quality Assurance (NCQA) Accreditation and compliance with contractual requirements
- Coordinate company-wide quality assessment and improvement activities
- Oversee and coordinate with corporate on annual file audits and other quality related initiatives, including those necessary to meet contract requirements
- Manage and implement appropriate work tools and processes, reports, and audit tools to ensure control of key processes and program characteristics
- Recommend QI opportunities based on findings to management and the Quality Improvement Committee (QIC) and other committees and participate in developing and implementing solutions, as appropriate
- Provide feedback to rectify errors and to prevent further inconsistencies
- Oversee monthly and quarterly reports and data to identify trends, opportunities for improvement, and interventions
- Align policies, operating procedures, and goals to achieve compliance with internal and external guidelines

Job Description

State Position Title: Medical Management Coordinator
Health Plan Position Title: Vice President, Population Health and Clinical Operations
Reporting Relationship: Chief Executive Officer

Position Purpose

Oversee and direct all population health functions for Nebraska Total Care based on, and in support of our strategic plan.

Education/Experience

Medical Doctor or master's degree in Nursing, Therapy, Pharmacy, or health care administration. MBA preferred. A minimum of eight years of clinical experience in the Healthcare industry. Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute, and improve clinical programs across Nebraska Total Care. Ability to identify, create and tracking clinical program opportunities for population health management. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions. Experience working with Medicaid population required. Position based in Nebraska.

Licenses/Certifications

Unrestricted license as MD, DO, PA, PT, OT, ST, RpH or PN in Nebraska.

Position Responsibilities

- Develop, implement, and monitor the provision of care coordination, disease management (DM), and case management functions
- Oversee the adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria. If, in the future, this position is required to make medical necessity determinations, it will be required to be filled by a state-licensed registered nurse, physician, or physician's assistant.
- Ensure the completion of appropriate concurrent review and discharge planning of inpatient stays
- Monitor, analyze, and implement appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services
- Monitor prior authorization functions and ensure that decisions are made in a consistent manner, based on clinical criteria, and meet timeliness standards
- Serve as a member of the Quality Assessment Performance Improvement Committee (QAPIC)
- Work with the Maternal Child Health (MCH) / Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator and Care Management Staff to provide comprehensive care and case management for members in the 599 CHIP program
- Lead complex projects including affordability analyses around medical and pharmacy expense, business analysis, documentation of business requirements, and defining current/future scope of work
- Create and manage clinical affordability projects with internal partners, including but not limited to pharmacy, other clinical and network affordability teams, and pilots
- Create innovative solutions and process enhancements to drive financial and quality success
- Lead Clinical Model development and process support in all approved state regions to align with the Clinical Model and meet program requirements by supporting reports, technology, and the core team
- Identify trends between Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Member Engagement; create programs/pilots to improve engagement with strategic partners
- Establish Nebraska Total Care's focus and direction regarding models of care that incorporate needs of all lines of business, focusing on quality and operational efficiencies across the organization
- Create and measure business and clinical outcomes with respect to the provision of clinical support for practice transformation and successful transition of practice to value-based contracting

Job Description

State Position Title: Provider Services Manager
Health Plan Position Title: Senior Director, Contracting and Network Development
Reporting Relationship: Vice President, Network Development and Contracting

Position Purpose

Oversee the development and implementation of contracting activities in network development and enhancement.

Education/Experience

Bachelor's degree in Healthcare Administration, Business Administration, or related field. A minimum of seven years of related contracting and/or equivalent healthcare experience. Experience establishing new markets including the development of the strategy and oversight of the implementation. Strong communication skills dealing with multiple levels within the organization and with the provider community. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. Experience working with Medicaid population required. Position is based in Nebraska.

Position Responsibilities

- Coordinate communications between Nebraska Total Care and its subcontracted providers; enhance MCO-provider communication strategies
- Manage the Provider Services staff
- Work collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns
- Develop provider training in response to identified needs or changes in protocols, processes, and forms
- Enhance communication strategies between Nebraska Total Care and provider community
- Notify the Division of Medicaid and Long-Term Care (MLTC) of correspondence sent to providers for informational and training purposes
- Participate in the MLTC Administrative Simplification Committee
- Serve as a member of the Quality Assessment Performance Improvement Committee (QAPIC)
- Work with Business Development and providers to create a strategy for developing new networks including plans to meet network access and Nebraska Total Care cost objectives
- Determine necessary resources to develop the network and assemble the appropriate team across all business functions
- Develop a budget in alignment with corporate network management and financial objectives
- Support the new business launch in diverse markets while considering individual market circumstances, the provider community, budgeting constraints, and available resources
- Lead the network development specialists during the implementation and development stages
- Monitor performance and address process and/or quality gaps
- Communicate with leadership regarding network strategy and planning
- Complete negotiations with complex and major provider contracts as needed to support network objectives

Job Description

State Position Title: Member Services Manager
Health Plan Position Title: Director, Customer Service
Reporting Relationship: Chief Operating Officer

Position Purpose

Direct and oversee the planning, development, and operation of assigned customer service function(s) and aid in formulating and administering organizational policies and procedures.

Education/Experience

Bachelor's degree in healthcare, business, related field, or equivalent experience. A minimum of seven years of diverse planning and management experience, preferably in a healthcare or insurance environment. Knowledge of applicable technologies, laws, regulations, and industry practices. Experience working with Medicaid population required. Position is based in Nebraska.

Position Responsibilities

- Coordinate communications between Nebraska Total Care and its members
- Direct Member Services department and staff to meet goals and objectives through effective planning, hiring, performance management, coaching, and career development
- Ensure that there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program
- Manage Member Services staff
- Serve as a member of the Quality Assessment Performance Improvement Committee (QAPIC)
- Assist in the formulation and development of strategies and oversee the planning and implementation of major projects, processes, and technologies
- Develop and implement performance standards and audit outcomes for the Member Services function
- Prepare annual budgets/forecasts for Member Services (or significantly assist in the process), analyze results, and ensure that the Member Services department meets budgeted expectations; identify and report significant variances to management as appropriate
- Ensure compliance with applicable policies, procedures, processes, outcomes, contractual agreements and State and Federal regulations
- Establish and implement best practices and standard operating procedures
- Manage relationships with key vendors and/or internal and external constituencies in support of Nebraska Total Care's strategic goals and objectives

Job Description

State Position Title: Claims Administrator
Health Plan Position Title: Manager, Claims Operations
Reporting Relationship: Chief Operating Officer

Position Purpose

Manage the day-to-day operations of the Claims Department to accurately and timely process members' medical claims.

Education/Experience

Bachelor's degree or equivalent experience. A minimum of three years of experience in operations management, financial management or analysis, or claims operations experience, preferably in a managed care setting. Two or more years in a supervisory capacity including hiring, training, assigning work and managing the performance of staff. Experience working with Medicaid population required.

Position Responsibilities

- Develop, implement, and administer a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with contract, State, and federal requirements
- Develop cost avoidance processes
- Meet claims processing timelines
- Ensure minimization of claims recoupments
- Meet MLTC encounter reporting requirements
- Resolve Claims Department processing/system issues within
- Prioritize work volumes daily
- Oversee the production status in the Claims Department to ensure production and quality goals are met
- Analyze the impact of new implementations on the Claims Department and reallocate staff duties as needed
- Assist in the development of the Claims Department annual budget
- Drive change initiatives to address future-oriented business needs
- Identify process and infrastructure needs to support change and consider a broad range of internal and external factors when making decisions

Job Description

State Position Title: Provider Claims Educator
Health Plan Position Title: Senior Manager, Provider Relations
Reporting Relationship: Provider Services Manager

Position Purpose

Oversee provider network to ensure appropriate access to care and quality member outcomes. Develop and implement activities for the recruitment and retention of effective providers. Partner with providers to monitor member health outcomes and oversee provider contract performance.

Education/Experience

Bachelor's degree or equivalent experience in managed healthcare environment. Master's degree preferred. A minimum of six years of program development, network development, provider relations, or provider training experience. Minimum of five years of management and supervisory experience in the health care field. Nebraska Medicaid Managed Care grievance, claims processing, and provider services systems knowledge. In-depth knowledge of state compliance and regulatory processes/laws. Experience working with Medicaid population required.

Licenses/Certifications

Current Nebraska driver's license.

Position Responsibilities

- Educate in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available Nebraska Total Care resources, such as provider handbooks, websites, provider training materials, and fee schedules
- Lead provider relations activities and oversee provider communication; communicate frequently with providers to ensure effective information exchange and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- Identify trends and guide the development and implementation of strategies to improve provider satisfaction
- Work with the call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements
- Directly interface with and represent Nebraska Total Care at provider forums to discuss issues and address the needs of the provider network
- Evaluate the need for additional providers, programs and/or specialty treatment services for identified populations based on analyses of network gaps
- Collaborate with all levels of the organization to verify accuracy of and analyze provider data to identify preferred practice patterns and provide further education to providers on integrated care, and network adequacy initiatives and expectations
- Develop and monitor training and education materials; oversee new provider orientation to maximize performance in service delivery and contract compliance
- Oversee the development of all provider mentor and corrective action workflows and processes associated with provider performance
- Develop and implement tactics to increase provider compliance and improve provider performance

Job Description

State Position Title: Case Management Administrator
Health Plan Position Title: Director, Clinical Operations
Reporting Relationship: Medical Management Coordinator

Position Purpose

Oversee and direct all population health functions for Nebraska Total Care based on, and in support of the company's strategic plan.

Education/Experience

Medical Doctor or Master's degree in Nursing, Therapy, Pharmacy, Public Health/Administration or related field. MBA preferred. A minimum of eight years of clinical experience in the health care industry. Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute, and improve clinical programs across Nebraska Total Care. Ability to identify, create, and track clinical program opportunities for population health management. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions. Must have experience as a case manager with a minimum of five years of management or supervisory experience in a health care field. Experience working with Medicaid population required. Position is based in Nebraska.

Licenses/Certifications

Unrestricted license as MD, DO, PA, PT, OT, ST, RpH or PN in Nebraska.

Position Responsibilities

- Oversee case management functions for Nebraska Total Care
- Work with other Nebraska Total Care staff to ensure that members' case management needs are met
- Work with the Medical Director and other population health and clinical operations staff to ensure that case management policies and protocols comply with federal and state requirements
- Lead complex projects including affordability analyses around medical and pharmacy expense, business analysis, documentation of business requirements, and defining current/future scope of work
- Create and manage clinical affordability projects with internal partners, including but not limited to pharmacy, other clinical and network affordability teams, and pilots
- Create innovative solutions and process enhancements to drive financial and quality success
- Lead Clinical Model development and process support in all approved state regions to align with the Clinical Model and meet program requirements by supporting reports, technology, and core team
- Identify trends between Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Member Engagement; create programs/pilots to improve engagement with strategic partners
- Establish the Nebraska Total Care's focus and direction regarding models of care that incorporate needs of all lines of business, focusing on quality and operational efficiencies across the organization
- Create and measure business and clinical outcomes with respect to the provision of clinical support for practice transformation and successful transition of practice to shared savings/risk contract

Job Description

State Position Title: Information Management and Systems Director
Health Plan Position Title: Director, Data Analytics
Reporting Relationship: Chief Financial Officer

Position Purpose

Lead analytical data needs for Nebraska Total Care.

Education/Experience

Bachelor's degree in data related field. A minimum of seven years of information systems experience, including data processing, and reporting. Advanced SQL and Microsoft Access skills, relational database knowledge, and various data reporting tool experience preferred. Knowledge of statistics and application of high-level mathematical models in medical and pharmacy claims data preferred. Experience working with Medicaid population required. Understanding of health insurance business, claims payment procedures, strategies, and trends in health care government programs preferred. Master's degree and supervisory experience preferred. Encounters experience preferred.

Position Responsibilities

- Establish and maintain connectivity with Division of Medicaid and Long-Term Care (MLTC) information systems
- Provide necessary and timely data and reports to MLTC
- Initiate and lead company wide data processes improvements
- Lead cross functional activities related to large-scale analytic projects to deliver on schedule, within budget and with superior quality
- Develop and lead activities to accomplish overall strategic department goals and lead the communication of these goals to stakeholders at all levels of the organization
- Collaborate with Nebraska Total Care leadership to understand their data analysis needs, explain trends in data, and actively drive further research and/or operational changes to assist in controlling medical costs and delivery of quality health care for members
- Participate in cross departmental initiatives and capabilities, including data analysis support
- Lead development efforts with technical team liaisons, including business requirements gathering and documentation, testing, delivery, and user adoption, and effectively communicate deliverable expectations
- Lead system/tool implementation and design as needed

Job Description

State Position Title: Encounter Data Quality Coordinator
Health Plan Position Title: Director, Data Analytics
Reporting Relationship: Chief Financial Officer

Position Purpose

Lead analytical data needs for Nebraska Total Care.

Education/Experience

Bachelor's degree in data related field. A minimum of nine years of data analysis experience, preferably in healthcare or seven years of related IT experience, including data warehouse, coding or ETL experience. Advanced SQL and Microsoft Access skills, relational database knowledge, and various data reporting tool experience preferred. Knowledge of statistics and application of high-level mathematical models in medical and pharmacy claims data preferred. Understanding of health insurance business, claims payment procedures, strategies and trends in healthcare government programs preferred. Master's degree and supervisory experience preferred. Encounters experience preferred. Experience working with Medicaid population required.

Position Responsibilities

- Coordinate services and communication between Nebraska Total Care administration and the Division of Medicaid and Long-Term Care (MLTC) for the purpose of identifying, monitoring, and resolving encounter data validation and management issues
- Serve as Nebraska Total Care's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions
- Analyze activities related to encounter data processing and data validation studies to enhance accuracy and output
- Initiate and lead company wide data processes improvements
- Lead cross functional activities related to large-scale analytic projects to deliver on schedule, within budget and with superior quality
- Develop and lead activities to accomplish overall strategic department goals and lead the communication of these goals to stakeholders at all levels of the organization
- Collaborate with Nebraska Total Care leadership to understand their data analysis needs, explain trends in data, and actively drive further research and/or operational changes to assist in controlling medical costs and delivery of quality health care to members
- Participate in cross departmental initiatives and capabilities, including data analysis support
- Lead development efforts with technical team liaisons, including documentation of business requirements; testing, delivery, and user adoption; and effective communication to Nebraska Total Care leadership and appropriate department(s) regarding deliverables
- Lead system/tool implementation and design as needed

Job Description

State Position Title: Tribal Network Liaison
Health Plan Position Title: Tribal Liaison and FQHC Representative
Reporting Relationship: Vice President, Network Development and Contracting

Position Purpose

Support provider and Nebraska Total Care activities related to performance improvement on cost, quality, coding and member outreach and engagement. Responsible for ongoing review of performance reporting and data, interpreting and prioritizing results and utilizing tools and resources to identify performance insights. Lead a team supporting provider performance in value-based agreements, including quality and utilization pay for performance and risk contracts.

Education/Experience

Bachelor's Degree in Healthcare Administration, Business Administration, or similar field or equivalent experience; Master's degree preferred. A minimum of five years of experience in managed care, value-based contracting, or clinical experience. Experience working with Medicaid population required. Position is based in Nebraska.

Position Responsibilities

- Plan and work with Provider Services staff to expand and enhance physical, behavioral health, and dental services for American Indian members
- Serve as the single point of contact with tribal entities and all Nebraska Total Care staff on American Indian issues and concerns
- Advocate for American Indian members with Case Management and Member Services staff
- Support provider performance improvement strategy at the plan and provider levels
- Analyze cost and quality data to interpret performance insights and prioritize provider actions
- Educate providers on the use of tools and interpretation of data and identify opportunities for improvement
- Understand member population and provider variation to effectively support providers with performance improvement
- Provide high-level recommendations to providers regarding opportunities to optimize clinical workflow to increase member outreach and care coordination
- Develop relationships with internal partners and key accounts

Job Description

State Position Title: Pharmacist/Pharmacy Director
Health Plan Position Title: Director, Pharmacy
Reporting Relationship: Chief Operating Officer

Position Purpose

Perform duties to develop, direct, and implement a pharmacy benefit management (PBM) program. Aid the Vice President of Medical Affairs in formulating and administering related organizational policies and procedures, including pharmacy service quality, pharmacy utilization management and achievement of Company goals for pharmacy and medical programs.

Education/Experience

Bachelor's degree or advanced degree (PharmD., M.S) in pharmacy. A minimum of three years of clinical pharmacy care experience, including experience supporting formularies, designing prior authorization requirements, and working with clinical information. Three or more years of recent contracting, quality improvement, and management experience in a healthcare environment, preferably managed care. Thorough knowledge of pharmaceutical care and pharmacy benefit management practices. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. Experience working with Medicaid population required. Position is based in Nebraska.

Licenses/Certifications

Current State Pharmacist license. Ability to receive license in additional states as required. Valid driver's license.

Position Responsibilities

- Oversee the prescription drug and pharmacy benefits; plan, direct, and implement pharmacy activities
- Lead formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving
- Consult on and coordinate pharmacy program changes
- Understand clinical pharmacy and drug product information to support plan benefit design in the point-of-sale (POS) system
- Oversee, monitor, and assist with the management of PBM activities
- Manage the prospective and retrospective drug utilization review (DUR) activities
- Support call center prior authorization programs and their development and/or modification
- Attend Division of Medicaid and Long-Term Care (MLTC) Pharmacy and Therapeutics Committee and DUR Board meetings; participate in other boards, task forces, committees, meetings, and other activities
- Meet with MLTC staff and the Nebraska Total Care PBM, no less than monthly, to discuss operational status updates, including the call center, POS system, grievances, and prior authorizations; as well as review performance standards and restricted services grievances and appeals
- Establish objectives, and policies and procedures for the pharmacy program in support of the strategic vision
- Resolve disputes, grievances, and complaints involving the pharmacy program
- Participate in external accreditation initiatives
- Manage relationships with key vendors such as the PBM and pharmaceutical companies
- Act as the pharmacy contract administrator for the development and implementation of key contracts and ensure relevant performance standards are met by vendors
- Support provider education initiatives such as counter detailing and incentive programs
- Manage and analyze operating costs and participate in preparing the annual budget for the assigned work function at both corporate and Nebraska Total Care
- Review and analyze reports, records, and directives, and confer with staff to obtain data required for planning work function activities
- Conduct statistical analysis of data related to assigned work function; prepare reports and records on data and the assigned work function activities for management and corporate

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B. Technical Approach

V.E Covered Services and Benefits

V.E Covered Services and Benefits

18. Provide the Bidder's definition of medical necessity. Describe the process for developing and periodically reviewing and revising the definition. Describe the degree to which the definition is consistent with or differs from MLTC's definition of medically necessity per 471 NAC 1-002.02A. ***Page Limit: 3***

Definition of Medical Necessity

Nebraska Total Care ensures all services and treatments are medically necessary to support the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development, and the ability to attain, maintain or regain functional capacity. ***Since 2017, we have aligned our definition of medical necessity with the Division of Medicaid and Long-Term Care's (MLTC's) definition per 471 NAC 1-002.02A to support consistency across Managed Care Organization (MCO) and fee-for-service enrolled members and providers***. We define medically necessary health care services and supplies as those which are:

- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner
- Rendered in a type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than the convenience of the member or the physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Relative to the goal of improved member health outcomes
- Of demonstrated value
- No more intensive level of service than can be safely provided

Nebraska Total Care applies its medical necessity definition consistently to reduce provider abrasion and ensure the appropriate use of MLTC's funds. We use qualified Nebraska Total Care Utilization Management (UM) staff to ensure timely prior authorizations (PAs) reflective of the differences in needs and access to care across Nebraska. As an example of how we support providers, we worked with an Omaha-based provider who was struggling with medical necessity documentation for social detox when receiving members from different referral sources, for example, law enforcement and emergency departments. Nebraska Total Care engaged the provider to educate on the necessary documentation for the referral source and the assessments needed to support timely and accurate authorizations from our UM team. We explained that we follow MLTC's and the American Society of Addiction Medicine's (ASAM's) Level 3.2 social detox service definition and clinical criteria for medical necessity. ***Since we reviewed medically necessary documentation with this social detox provider, 100% of the members in question received same-day services and the provider has experienced decreased administrative burden related to review time***.

Provider Partnership to Ensure Medically Necessary Services

We received a call from a provider who felt like he was getting too many denials for sacroiliac joint injections for low back pain. Upon review of the authorization requests, we learned that 60% of his requests were approved and all adverse determinations were due to documentation not meeting medical necessity requirements. Our Provider Relations Representative, specialty-matched peer reviewer, and Chief Medical Officer met with the provider to share the data and provide medical necessity education. Dr. Haake, the peer reviewer, conducted several follow-ups to further support the provider.

Process for Developing, Reviewing, and Revising Medical Necessity Definition

Developing Medical Necessity Criteria. Nebraska Total Care grounds our medical necessity definition in MLTC's definition of medical necessity per 471 NAC 1-002.02A. We also consider Nebraska Medicaid covered services and benefits; nationally recognized, evidence-based standards of care; and legislative and regulatory standards declared at the Federal and Nebraska level when developing medical necessity criteria. **Table 18.A Evidence-based Standards of Care** includes some of Nebraska Total Care's sources in developing our definition of medical necessity. Before adopting preventive and clinical practice UM guidelines, we also seek to align with the health needs and opportunities for improvement identified as part of the Quality Assessment and Performance Improvement (QAPI) program, guidance from statewide collaboratives, and a consensus of health care professionals in the relevant field.

Table 18.A Sample of Evidence-based Standards of Care Resources used by Nebraska Total Care

Health Care Type	Standards of Care Resource
Physical Health (Including Related Pharmacy)	Advisory Committee on Immunization Practices • American Academy of Pediatrics • American Academy of Neurology • American Board of Internal Medicine Foundation • American College of Cardiology • American College of Endocrinology • American College of Obstetricians and Gynecologists • American College of Physicians • American Geriatrics Society • American Heart Association • Association of Maternal & Child Health Programs • Centers for Disease Control and Prevention (CDC) • National Comprehensive Cancer Network • National Heart, Lung, and Blood Institute • National Institutes of Health • U.S. Department of Health and Human Services • U.S. Preventive Services Task Force
Behavioral Health (Including Related Pharmacy)	American Academy of Child and Adolescent Psychiatry • American Academy of Pediatrics • American Psychiatric Society • ASAM • CDC • National Institute for Health and Care Excellence • Substance Abuse and Mental Health Services Administration • The Council of Service Providers • U.S. Department of Defense • U.S. Department of Veterans Affairs
Pharmacy	American Pharmacists Association • American Society of Health-system Pharmacists
Dental Health	American Academy of Pediatric Dentistry • American Academy of Pediatrics • American Dental Association

Reviewing and Revising Medical Necessity Criteria. When MLTC issues Provider Bulletins, Health Plan Advisories, or regulatory updates that impact covered services, authorization processes, or its definition of medical necessity, Nebraska Total Care takes the following steps to revise and review our definition of medical necessity:

- Review and vet updates with our Clinical Advisory Committee (CAC) and our Provider Advisory Committee (PAC)
- Create a Nebraska Total Care provider communication to share the updated information via our website, Provider Newsletters, town hall meetings, and with committees in our QAPI Committee structure
- Providers are given 60 days advance notice of changes whenever possible, or if MLTC establishes an effective date faster than 60 days, we communicate MLTC's effective date

For example, when we received Provider Bulletin 21-23 regarding respiratory syncytial virus (RSV) season on December 22, 2021, we quickly disseminated the bulletin to the CAC and PAC for review. This bulletin directed MCOs to approve, as medically necessary, coverage of a sixth, seventh, or eighth dose of Synagis, when appropriate. Our UM and Provider Relations teams received guidance from CAC and PAC to notify our provider network immediately to support MLTC's RSV season extension and coverage requirement.

In addition to the resources described above, the CAC reviews updates provided annually by the InterQual Connect™ evidence-based physical health (PH) and behavioral health (BH) clinical decision support solution. InterQual Connect delivers a straightforward, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. Nebraska Total Care staff and providers receive revision information through training opportunities and via Provider Handbooks, Bulletins, bi-weekly newsletters, QAPI materials and guidelines, and other resources on our provider website. We post clinical, pharmacy, and dental payment policies on our website. Provider Relations staff are always available to answer provider questions.

Proven Results

Nebraska Total Care's approach to medical necessity, UM, and PAs works as shown by our 2021 results:

- 99.9% of PH PAs determined within 14 days
- 99.7% of PH expedited reviews determined within 72 hours
- 97.8% of PH concurrent reviews determined within 72 hours
- 99.9% of BH PAs determined within 14 days
- 100% of BH expedited reviews determined within 72 hours
- 99.7% of BH concurrent reviews determined within 72 hours

Applying Medical Necessity Criteria

Nebraska Total Care's process for determining medical necessity considers the individual member's needs and circumstances while incorporating evidence-based guidelines and criteria, guidance from qualified health professionals, and utilization of state-of-the-art tools and technology. We share IRR reports annually at CAC, PAC, UM, and QAPI Committee meetings. These committees can recommend quality improvement projects based on IRR reports. We follow all medical necessity requirements in RFP Section V.E of the Scope of Work for PH, BH, telemonitoring, non-emergency medical transportation, dental services, pharmacy services, concurrent review, and member transition and enrollment. We

embed our medical necessity guidelines in our policies and procedures to prevent arbitrary decisions to deny or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or member condition.
We also adhere to RFP Section V.D by ensuring only state-licensed registered nurses, physicians, or physician's assistants have final authority for medical necessity policies, procedures, and determinations. Nebraska Total Care applies two levels of UM medical necessity review for all authorization requests. Reviews are conducted by Nebraska Total Care staff to ensure responsiveness to a member's individual needs, the community in which they live, and the services available. Nebraska Total Care staff are fully trained to apply InterQual Connect guidelines and must complete inter-rater reliability (IRR) validation before making medical necessity decisions. Staff is validated annually to ensure we apply medical necessity criteria accurately and consistently.

19. Provide a description of the value-added services the Bidder proposes to offer to members taking into consideration OIG Advisory Opinion No. 20-08. For each service:
- *Define and describe the service.*
- *Identify the category or group of members eligible to receive the service if it is not appropriate for all members.*
- *Note any limitations or restrictions that apply to the service.*
- *Identify the types of providers responsible for providing the service.*
- *Propose how and when members and providers will be notified of the service's availability.*
- *Describe how a member may obtain/access the service.*
- *Describe how the Bidder will identify the expanded benefit in administrative or encounter data.*

Page Limit: Not applicable

Nebraska Total Care's Approach to Value Added Services (VASs)

Since 2017, Nebraska Total Care's comprehensive package of VASs has helped members achieve personal health and wellness goals while supporting the Division of Medicaid and Long-Term Care's (MLTC's) overall goals for Heritage Health enrollees. ***Since the issuance of the Office of Inspector General's (OIG's) Advisory Opinion No. 20-08, Nebraska Total Care has worked with MLTC to adjust our VASs for compliance with the opinion while ensuring members have additional benefits and incentives to improve their health.*** As an example, we adjusted our My Health Pays Rewards Program incentives for annual well-child visits from $25 to $10 to support nominal value limits while still encouraging preventive care utilization. We do not submit VAS for MLTC review if it conflicts with the OIG opinion to ensure we are following the intent of VASs as described by MLTC. Finally, we also have selected benefits that wrap around, but do not duplicate, benefits for members dually enrolled in Medicare and Medicaid, including those enrolled in our existing Highly Integrated Dual Eligible Special Needs Plans (HIDE SNP). As a continuation of our partnership with MLTC, all newly proposed and enhanced VASs in this response were reviewed by our legal department for compliance with OIG Advisory Opinion No. 20-08.

In **Table 19.A**, Nebraska Total Care proposes a suite of current and new VASs designed to improve the health of members, address health equity, and advance MLTC's goals for reducing non-emergent use of the emergency department (ED) and for improving maternal and child outcomes in prenatal, postpartum, and inter-pregnancy care. For example, our Notification of Pregnancy (NOP) incentives encourage women to report pregnancies early, allowing our Care Management team to reach out to members for Care Management and Social Determinants of Health (SDOH) screenings, enroll members in our ***Start Smart for Your Baby®*** (Start Smart) program, and help schedule prenatal visits. As a result of our earlier prenatal intervention, Nebraska Total Care realized these improvements:

- Prenatal visits for Hispanic members increased by 13.4% between 2018 and 2021.
- The health equity gap closed between Hispanic members and White members during the same period, with Hispanic members now experiencing fewer neonatal intensive care unit (NICU) days than White members in 2021.
- The average length of stay in the NICU for all members was reduced by 7% from 2018 to 2021.

We integrate VASs into our population health management strategy to ensure all eligible members are aware of and can access VASs. Additionally, we stratify our member data by race/ethnicity, geography, age, gender, language, and disability status to determine where health differences exist and then target our outreach to each VAS's priority sub-population to address health equity across Nebraska. We train our Care Management staff, Community Health Workers (CHWs), provider network, and community-based partners on VASs to increase utilization. We educate our members about VASs through our website, Welcome Packets, and outreach activities to help members use all tools available to improve their health.

Nebraska Total Care's Quality Assessment and Performance Improvement (QAPI) Committee and Health Equity and Diversity Committee (HEDC) provide oversight and monitoring for all VASs by reviewing utilization data plus process and outcome measures. Our QAPI Committee oversees health, wellness, and quality outcomes across our entire population. Reporting to the QAPI Committee, the HEDC will review the impact of VASs on reducing inequities and make recommendations for improvements or future VAS offerings to maintain alignment with MLTC's priorities. While the impact of VASs is monitored continuously, all VAS benefits are reviewed annually ahead of open enrollment and, following MLTC-approved changes for the upcoming year, are posted to the website. This allows members to make informed benefit decisions during the open enrollment period.

Table 19.A – Nebraska Total Care's Proposed VASs

	Impacts Non-emergent ED Use	Impacts Maternal Child Health	Impacts Behavioral Health	Impacts Physical Health	Impacts SDOH	Currently Approved VAS	Newly Proposed or Enhanced VAS
24/7 Behavioral Health Crisis Line	✓	✓	✓	✓	✓	✓	
24/7 Nurse Advice Line	✓	✓	✓	✓	✓	✓	
Adolescence to Adulthood Program			✓	✓	✓		✓
Adult Immunizations				✓		✓	
Boys & Girls Clubs Membership			✓	✓	✓	✓	
Breastfeeding Support Mobile App	✓	✓	✓	✓	✓		✓
Client Assistance Program	✓		✓			✓	
Community Baby Showers		✓			✓	✓	
Community Garden Sponsorship				✓	✓	✓	
ConnectionsPlus® Connectivity Assistance	✓	✓	✓	✓	✓	✓	
Dental Kits for Kids		✓		✓	✓		✓
Digital Behavioral Health Platform	✓		✓			✓	
Digital Wellness Support Program	✓		✓	✓		✓	
Doula Services		✓	✓		✓		✓
Electric Breast Pumps		✓		✓	✓	✓	
Enhanced Transportation for Pregnant and Parenting Members		✓		✓	✓	✓	
Findhelp Community Resource Platform	✓	✓	✓	✓	✓	✓	
Friendly Voices Program			✓	✓	✓		✓
GED Tutoring and Test Prep Kits					✓		✓
Interpretation Services at Provider Offices	✓	✓	✓	✓	✓	✓	
Kits for Children and Youth in Foster Care					✓	✓	
Krames Staywell Health Library	✓			✓	✓	✓	
My Health Pays™ Rewards Program	✓	✓	✓	✓	✓	✓	
My Route to Health	✓			✓	✓	✓	
NICU Support Kits		✓		✓	✓	✓	
Phoebe's Kids Club			✓	✓		✓	
Practice Dental Visits for Members with Special Health Care Needs	✓		✓	✓			✓
Screening, Brief Intervention, and Referral to Treatment		✓	✓			✓	
Sickle Cell Disease Comfort Kits				✓		✓	
Sports and Camp Physicals				✓	✓	✓	
Start Smart for Your Baby® Plus Support Items		✓		✓	✓	✓	✓
Supermarket Pharmacy Diabetes Program	✓			✓	✓		✓
Value Add Drug List	✓		✓	✓	✓	✓	
Weight Watchers				✓		✓	
YMCA Membership			✓	✓		✓	

We understand that MLTC must approve any VAS proposed by Nebraska Total Care and additions, deletions, or modifications to approved VAS made during the contract period must be submitted to MLTC for approval a minimum of 45 calendar days before their implementation. We have complied with this requirement throughout our current contract. We will send the member a notification letter if the Value Added Service is not approved and work with them to find Nebraska Total Care programs, covered services alternatives, and community resources that can support their needs.

The following pages include descriptions of the VASs listed in **Table 19.A** in alphabetical order.

VAS Descriptions

24/7 Behavioral Health (BH) Crisis Line

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, our 24/7 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.***

Definition and Description of Service. Licensed BH clinicians staff our 24/7 BH Crisis Line. They use their clinical skills to de-escalate crises and connect members to follow-up care that does not require prior authorization (PA), including community mental health centers, our BH provider network, mobile crisis services, or our Client Assistance Program VAS. If the level of risk is indicated to be urgent/emergent, the BH clinician contacts local providers, or the necessary authorities, to intervene as appropriate. 24/7 BH Crisis Line staff stay on the call with the member or family until emergency services arrive, or until referral to an appropriate provider is scheduled.

BH Crisis Line staff document all interactions in an application integrated with TruCare Cloud, Nebraska Total Care's integrated health management platform, so that all interactions are viewable by Care Managers.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. There are no limitations or restrictions on access or utilization of the 24/7 BH Crisis Line.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's 24/7 BH Crisis Line is staffed by licensed BH clinicians. Our BH clinicians use clinical skills to de-escalate crises, assess callers using evidence-based tools, and connect members to follow-up care such as community mental health centers or other mobile crisis services that do not require PA.

How and When Members and Providers Will Be Notified of VAS. We inform members of our 24/7 BH Crisis Line through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also provide information about this VAS when interacting with members. We inform providers through our Provider Handbook, during training, and in newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access the 24/7 BH Crisis Line by calling 844-385-2192 and selecting the line from the main menu. Members with hearing impairments may use 711 for service. Nebraska Total Care also uses translation services for members who prefer to communicate in a language other than English. Our Member Services Call Center staff are trained to listen for key emergency words and phrases, caller voice volume and tone, and other indicators of stress to facilitate a warm transfer to our BH Crisis Line when appropriate. If necessary, our staff will dial 911 for the caller while keeping them on the line.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the 24/7 BH Crisis Line are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

24/7 Nurse Advice Line (NAL)

For the last 20 years, nurses have ranked as the most trusted profession in the United States in Gallup's Honesty and Ethics poll.[1] 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

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.

[1] Kathleen Gaines. "Nursing Ranked as the Most Trusted Profession for 20th Year in a Row." *Nurse.org*, 19 Jan 2022, https://nurse.org/articles/nursing-ranked-most-honest-profession/.

safely treated at home. ***In 2021, our 24/7 NAL received 1,863 calls, of which 35% were clinical.***

Definition and Description of Service. Members can call the 24/7 NAL any time they or a family member are having symptoms of an illness or medical problem, or they can call with general health questions. Using evidence-based algorithms or guidelines, our 24/7 NAL nurses quickly and accurately triage calls and direct the member to information or resources, which could include education on how to care for and manage the condition at home, a referral for an in-person physician visit, or immediate referral to an urgent care center or ED. For example, members experiencing chest pain will be told to call 911 or go immediately to the ED.

During non-urgent situations, the 24/7 NAL nurse offers care management advice and health education related to the member's health concern to increase confidence in disease self-management skills. For example, the nurse can help interpret test results or in understanding a prescribed regimen and diet. Our 24/7 NAL staff document all calls in an application integrated with TruCare Cloud so that all interactions are viewable by Care Managers. Nurses also serve as an additional channel for identifying, referring, and enrolling members in Nebraska Total Care's Care Management programs, including ***Start Smart***. Finally, our 24/7 NAL staff helps members locate in-network health care providers and facilities.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. There are no limitations or restrictions on access or utilization of the 24/7 NAL.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's 24/7 NAL is staffed by licensed nurses. Nurses have access to BH clinicians for BH concerns or crises.

How and When Members and Providers Will Be Notified of VAS. We inform members of our 24/7 NAL through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also provide information about this VAS when interacting with members. We inform providers through our Provider Handbook, during training, and in newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access the 24/7 NAL by calling 844-385-2192 and selecting the line from the main menu. Members with hearing impairments may use 711 for service. Nebraska Total Care also uses translation services for members who prefer to communicate in a language other than English. Our Member Services Call Center staff warm transfer calls to the 24/7 NAL and then disconnect for privacy.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the 24/7 NAL are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Adolescence to Adulthood (a2A) Program (*New VAS)

Challenges are well-documented for youth transitioning from the foster care system to independent living and adulthood. Youth who age out of the foster care system are at higher risk for unemployment, homelessness, lower educational attainment, and long term physical and mental health issues. Nebraska Total Care has served children and youth in foster care since 2017. Currently, we have at least 3,300 Foster Care members enrolled each month, with an average of 5.5% receiving Care Management services with these outcomes:

- Children and youth in foster care had a 13% increase in PCP visits between 2020 and 2021, indicating increased engagement in preventive care.
- Between 2018 and 2021, children and youth in foster care had a 37.4% increase in BH-related PCP spend per member per month (PMPM), while BH-related inpatient spend decreased by 41.9% PMPM, and BH-related ED spend also decreased by 48.3% PMPM.

To help youth in foster care succeed, Nebraska Total Care will launch the ***a2A Program*** to provide specialized, goal-oriented care management to transitional age youth in foster care. ***Our Illinois affiliate's a2A program achieved increased referrals to help youth meet their goals, including 41% connected to housing or independent living programs, 58% connected to employment assistance, and 48% connected to GED, trade school, or college assistance.***

Definition and Description of Service. The a2A Program is a specialized Care Management program for youth aging out of the foster care system developed by our parent company, Centene. Care Management staff help members acquire skills through education and coaching to self-manage their health care and transition to independent living. For youth choosing to enter a2A, Care Managers administer an Adverse Childhood Experiences (ACE) Questionnaire to determine their ACE score which reveals strong predictors of later health risks and disease. Enrolled members are matched with a Care Manager to discuss future risk factors and develop a Healthy Living Plan. As part of the program, we will also connect youth to our My Health Pays Rewards Program (described below), which allows members to earn financial rewards for completing preventive care visits that can be used on needed items such as food, clothing, transportation, utilities, and education to support the transition to independence.

Eligible Members. All youth in foster care ages 16 and older will be eligible for the a2A Program.

Limitations or Restrictions. There will be no limitations on a2A Program participation.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's Care Managers trained on a2A Program processes and ACEs will provide this VAS.

How and When Members and Providers Will Be Notified of VAS. We will inform members of the a2A Program in the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs with specialization in the foster care system will also provide information about the benefit when interacting with members in foster care, Department of Health and Human Services (DHHS) social workers, and foster care community-based organizations (CBOs). We purposefully outreach members in foster care who are aging out to help them complete a new Medicaid application so they do not lose coverage if eligible. Nebraska Total Care will inform providers of the benefit through the Provider Handbook, provider training, and communications including newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members, foster parents, family, and providers can request a2A Program enrollment by contacting our Member Services Call Center, their Care Manager or CHW, or via our website.

Identification of the Expanded Benefit in Administrative or Encounter Data. We will track participation in the a2A program in TruCare Cloud. Care Management staff will update the plan of care with the member's identified goals for education, employment, housing, and health. We will also track referrals to community resources, covered services, or other Nebraska Total Care VAS. Costs associated with the a2A Program will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

The Nebraska Total Care Difference

We will launch a customized Findhelp Foster Care social needs resource and referral database. This enhanced tool will increase our ability to connect transition age youth in foster care to no-cost and low-cost community services targeted to their unique needs.

Adult Immunizations

Routine vaccination against highly transmissible diseases is important for adults with chronic health conditions, pregnant women, and adults over age 65. For example, influenza (flu) vaccination can reduce the risk of flu-associated hospitalization. ***One in three Nebraska Total Care members received their flu shot in 2021 following our Fluvention outreach program.***

Definition and Description of Service. Nebraska Total Care covers annual flu, pneumonia, shingles (for adults over age 50), meningitis, HPV (human papillomavirus), and Tdap (tetanus, diphtheria, and pertussis) vaccines for members ages 18 and older when administered by a network provider or pharmacy. After the end of the COVID-19 Public Health Emergency (PHE), we will cover COVID-19 vaccinations if recommended for adults and no other source of coverage exists.

Eligible Members. All adult members ages 18 and older are eligible for this VAS.

Limitations or Restrictions. There are no restrictions on this benefit, but members are limited to receiving one vaccination per vaccination type each calendar year. Members need to meet age or medical necessity criteria for some vaccines, for example, the age requirements for the shingles shot.

Types of Providers Responsible for Providing the VAS. A member's provider or pharmacies in Nebraska Total Care's network provide this expanded benefit.

How and When Members and Providers Will Be Notified of VAS. We inform members of this enhanced benefit through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during training, and in newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. A member may self-refer to their PCP or pharmacy or call our Member Services Call Center for assistance in locating participating pharmacies. Members can also access vaccines at Nebraska Total Care-sponsored community health events.

Identification of the Expanded Benefit in Administrative or Encounter Data. Once claims are adjudicated to a finalized status in our Claims Processing System, they are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Boys & Girls Clubs Membership

Boys & Girls Clubs aims to minimize violence, peer pressure, and other risky activities by engaging young people in activities with positive adult role models and peers, enabling them to realize their full potential as productive, responsible, healthy, and caring members of society.

Definition and Description of Service. Boys & Girls Clubs membership includes dedicated space for homework help, nutritious evening meals, access to the latest technology, leadership, education, health, art and recreation programs, career development education, and mentoring opportunities.

Eligible Members. We cover the cost of an annual membership for members ages 6 to 18 years.

Limitations or Restrictions. Members are subject to the rules and regulations of the respective Boys & Girls Club they choose to join. Members are limited to one membership per year. Members are limited to the service areas of the Boys & Girls Club.

Types of Providers Responsible for Providing the VAS. Boys & Girls Clubs of the Midland and Boys & Girls Clubs of Lincoln/Lancaster County provide this service. They directly bill Nebraska Total Care for the membership fee.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. The Boys & Girls Clubs routinely collect participants' insurance information upon enrollment. When Nebraska Total Care is identified as the child's health plan, they inform the parent they will bill Nebraska Total Care and do not collect the fee from the family. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members may self-refer by going directly to the Boys & Girls Club location and showing their Nebraska Total Care member identification (ID) card. If additional assistance is needed, Member Services or the member's Care Manager will assist the family with locating and enrolling in their local Boys & Girls Club.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track participation in Boys & Girls Clubs through invoices submitted by the program. Costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Breastfeeding Support Mobile App (*New VAS)

Breastfeeding has health benefits for both infants and moms. Breast milk helps to strengthen an infant's immune system, thus resulting in fewer cases of illness for newborns. Breastfeeding can also decrease the risk of breast and ovarian cancer in mothers and may decrease the risk of postpartum depression.[2] The Nebraska Perinatal Quality Improvement Committee is working with hospitals to increase exclusive breastfeeding rates. Currently, the in-hospital-wide exclusive breastfeeding is at 75% and breastfeeding initiation is at 90%. Sometimes parents need additional support to sustain breastfeeding or to answer other emergent questions—often during non-business hours. ***To support the breastfeeding goals of our partners and improve maternal and child health, Nebraska Total Care will offer access to Pacify, a 24/7 Digital Pregnancy Health Platform, that uses a nationwide network of nurses and doulas to provide lactation support and maternal child health education.***

Proven Results

Pacify has shown a 26% decrease in non-emergent ED visits by reaching new parents in their moment of crisis. Pacify also increases breastfeeding rates by 23%.

Definition and Description of Service. As part of our award-winning ***Start Smart*** program, we offer members the Pacify platform for 24/7 on-demand access to maternal and pediatric experts for lactation support, member education, and other related topics. Pacify's tech-enabled platform provides 24/7 perinatal and infant feeding support to new and expecting parents via their smartphones. The Pacify app connects families to a nationwide network of lactation consultants and registered nurses within minutes, reducing costs and improving outcomes. Nebraska Total Care and Pacify will build on existing resources in the State, including leveraging the WIC lactation hotline for breastfeeding support. Members can opt to receive push notifications, emails, texts, and social media content on topics such as prenatal nutrition to influence member health care decisions, for example, prenatal care, postpartum visits, immunizations.

Eligible Members. All members who are pregnant or postpartum for up to one year will be eligible for Pacify.

Limitations or Restrictions. There are no limitations or restrictions on Pacify use or access.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care will contract with Pacify to provide this VAS.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will also provide information about this VAS when interacting with members at community events or in response to an NOP. Members requesting electric breast pumps will be informed of this VAS. We will inform providers through the Provider Handbook, during

[2] "Nebraska Minorities Disparity Facts Chart Book." *Office of Health Disparities & Health Equity, Division of Public Health, Nebraska Department of Health & Human Services,* 2021. https://dhhs.ne.gov/Reports/Nebraska%20Disparities%20Chartbook%202021.pdf.

provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access Pacify app via any smartphone or computer. We will enroll members in our ***ConnectionsPlus VAS*** if they need reliable phone service. Our Care Managers will also provide onboarding and technical support to ensure members with low digital literacy can appropriately and effectively access this VAS.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with this VAS will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Client Assistance Program (CAP) for BH

We believe members should have access to BH services quickly and conveniently to fully manage their health and wellness. In 2021, five of the top 10 chronic conditions for Nebraska Total Care members were BH-related. To fully address member BH needs, Nebraska Total Care has increased access to BH services through integrated primary care and BH settings and BH telehealth options. To continue to increase access to preventive and less costly BH care, Nebraska Total Care's CAP VAS allows any member to seek brief, solution-focused therapy services and support their mental health without the challenge of scheduling an Initial Diagnostic Interview (IDI). This helps members with mild or emerging BH concerns address issues quickly. ***In 2021, we provided 4,899 CAP sessions to members.***

Definition and Description of Service. Nebraska Total Care covers up to five outpatient BH therapy sessions annually without an IDI. Sessions may be in-person or virtual to ease access and privacy concerns, particularly in rural and frontier communities. CAP sessions can support members experiencing depression, anxiety, or who need help quitting substances like tobacco or alcohol.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. Members must utilize a Nebraska Total Care BH provider. Without an IDI, CAP sessions are limited to five per year. If five sessions are insufficient, members can complete the IDI with their provider to determine the medical necessity for additional sessions and establish a treatment plan.

Types of Providers Responsible for Providing the VAS. Members can visit any Nebraska Total Care BH provider, in person or by telehealth, for CAP sessions.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers, CHWs, NAL, and BH Crisis Line staff also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can contact providers directly for services. Members may also contact our Member Services Call Center or their Care Manager for help finding a provider.

Identification of the Expanded Benefit in Administrative or Encounter Data. Once claims are adjudicated to a finalized status in our Claims Processing System, costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Community Baby Showers

Nebraska Total Care's ***Start Smart*** program incorporates the concepts of Care Management, Care Coordination, and disease management to improve the health of birthing parents and their newborns. The program's multi-faceted approach to improving prenatal and postpartum care includes enhanced member outreach and incentives, wellness materials, intensive care management, provider incentives, and support for the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

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[3], ***Pomelo's virtual model increases our members' access to this verified approach to reducing preventable NICU stays.***

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

Definition and Description of Service. Our CHWs host baby showers for our pregnant and recently delivered members. We send out an invitation to all identified new moms and moms-to-be in the surrounding community and structure the event to feel like a typical baby shower. The baby showers provide an opportunity to educate members about infant care, lead poisoning, the importance of scheduling well visits, and paying attention to developmental milestones. Attendees receive an infant personal care kit that includes nail clippers, a brush, and a comb as an incentive to participate. In some cases, baby showers are incorporated as part of an event hosted by a local community organization. For these events, Nebraska Total Care sets up a booth and provides the same educational materials and baby items. Baby showers may also include participation from a Care Manager who can provide personalized education, answer members' questions or concerns, and help connect them to services in the community.

Eligible Members. All pregnant members and members up to one year postpartum are eligible to participate in Community Baby Showers.

Limitations or Restrictions. Members may participate in multiple baby showers but will receive one set of baby items per pregnancy.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care CHWs or Care Managers are responsible for providing this VAS. We also partner with community groups and providers such as OneWorld Community Health Centers, Ponca Tribe of Nebraska, Hastings Healthy Beginnings, Bluestem Health, and North Omaha Breastfeeding Collaborative to provide community baby showers.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also outreach members with NOPs to provide information about this VAS. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members receive invitations to Community Baby Showers from Nebraska Total Care and our community partners but may attend any announced Community Baby Shower event. Members must be present at the baby shower to receive baby items.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track participation in Community Baby Showers in TruCare Cloud. Costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Community Garden Sponsorship

A 2020 Nebraska legislative report indicated that 12.3% of all Nebraskans and 16.7% of children experience food insecurity.[4] In 2019, only 7.3% of Nebraskans reported consuming two or more fruits and three or more vegetables daily. The number drops for Nebraskans with lower educational attainment, males, and Hispanics.[5] A healthy, varied diet is important for managing chronic conditions and improving health and wellness. To help members improve their health and food security, Nebraska Total Care sponsors community garden plots for members. ***In 2022, we connected 60 members to the community garden in their neighborhood. For members without an accessible community garden, we provided a container garden kit from Community Crops.***

Definition and Description of Service. Nebraska Total Care pays for one community garden plot per household. Members must establish and maintain the garden with support from the community garden organization.

Eligible Members. All members are eligible.

Limitations or Restrictions. We limit sponsorship to one plot per household per year.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care has relationships with community gardens statewide. If a member identifies a new community garden location, we will engage the garden to pay for the plot.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

[4] Elise Hubbard. "Food Insecurity." *Legislative Research Office, Nebraska Legislature*, Sep 2020, https://www.nebraskalegislature.gov/pdf/reports/research/food_insecurity_2020.pdf.
[5] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/annual/measure/fvcombo/state/NE, accessed 7 Jun 2022.

How Members May Access the VAS. Members may contact the community garden directly or contact our Member Services Call Center for help locating a garden.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track participation in this VAS through invoices submitted by community garden partners. Costs associated with community gardens are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

ConnectionsPlus® Connectivity Assistance

Mobile phones with sufficient talk, text, and data packages and Internet connectivity reduce barriers to care for Medicaid members. According to the most recent data available (2018), 13.8% of Nebraska households lacked Internet services and 11.2% were reliant on cellular data plans.[6] Nebraska Total Care offers connectivity support to members to facilitate access to Care Management, telehealth, PCPs and other providers, community-based resources, and digital health resources.

Definition and Description of Service. Nebraska Total Care provides pre-programmed smartphones, data plans, and MiFi hotspots to members engaged in Care Management who lack reliable phone access.

Eligible Members. Members enrolled in Care Management with an identified connectivity need are eligible. We will help eligible members access the Nebraska Telephone Assistance Program (NTAP, also known nationally as the Lifeline Program) before enrolling in ConnectionsPlus.

Limitations or Restrictions. Members must be ineligible for the Nebraska Telecommunications Assistance Program. Members must agree to be enrolled in our Care Management program and have a high-risk diagnosis or disease state. Members are limited to one smartphone. Members must return the phone within four weeks of disenrollment from Nebraska Total Care.

Types of Providers Responsible for Providing the VAS. We have partnerships with all major carriers in Nebraska through our parent company, Centene. ConnectionsPlus phones and data packages will be provided to the member based on which carrier has the best connectivity in the member's neighborhood.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members or providers may initiate a request through a Care Manager, CHW, or Member Services Call Center representative. A Care Manager will outreach to the member telephonically to determine if the member qualifies and then arrange for a face-to-face visit to deliver the phone, program it with appropriate numbers, test the phone to ensure it works as anticipated, and review return guidelines with the member.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track participation in ConnectionsPlus in TruCare Cloud and through invoices provided by our ConnectionsPlus partners. Associated costs are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

'Joe's' Story: Helping Rural Members Access Care. Joe recently had multiple strokes and was diagnosed with kidney disease. He was seeing several providers, needed daily dialysis, and was experiencing anxiety related to his new diagnoses and inability to afford his cell phone. Because he lived in a rural community, he struggled with getting transportation to his providers and began to frequent the ED for care. Our Care Manager (CM) reached out to Joe to help coordinate his care. Our CM helped Joe obtain a cell phone through our ConnectionsPlus program, allowing him to communicate regularly with his providers and our CM. Our CM also ensured Joe had the medicines he needed at home and helped him access transportation for future appointments. As a result, Joe has less anxiety and feels more confident in managing his health.

Dental Kits for Kids (*New VAS)

Dental health is an important part of whole-person health. Tooth decay, cavities, and gum disease can cause pain, tooth loss, and infection if left undiagnosed and untreated. For children, untreated cavities can lead to school absences and poor academic outcomes. Poor dental health during early childhood can impact health into adolescence and adulthood, including increasing the risk of cardiovascular disease. America's Health Rankings data from 2019-2020 shows that 17.6% of

[6] Cynthia Nigh. "Nebraska's Great Broadband Divide: Living Without High-speed Internet Access." *Nebraska Library Commission,* 7 Aug 2020. http://nlcblogs.nebraska.gov/nlcblog/2020/08/07/nebraskas-great-broadband-divide-living-without-high-speed-internet-access/.

Nebraska children ages 1 to 17 years did not have at least one preventive dental care visit in the previous 12 months.[7] Nebraska Total Care wants to help members develop lifelong dental habits by promoting regular dental check-ups and good dental hygiene in between dental check-ups.

Definition and Description of Service. Nebraska Total Care's Dental Kits for Kids will include one full-size fluoride toothpaste, a spin brush-style electric toothbrush, and other supplies. We will also include age-appropriate dental health educational items, such as coloring sheets, Darby Boingg books, and fact sheets. We will include a list of nearby network dentists and information about transportation options to remove barriers to care.

Eligible Members. All members who are three years old and who have not had a preventive care dental visit in the previous 12 months will be eligible for this VAS.

Limitations or Restrictions. Members will receive one Dental Kit.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care will provide Dental Kits.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also provide information about this VAS when interacting with members. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. We will identify members by reviewing enrollment files and claims data monthly to locate members meeting eligibility criteria. We will send eligible members a Dental Kit. Members may also request a Dental Kit by calling our Member Services Call Center or by contacting us through our public website.

Identification of the Expanded Benefit in Administrative or Encounter Data. We will isolate costs for Dental Kits into a specific cost center and provide information to MLTC in our Administrative Expense Reports.

Digital BH Platform

The COVID-19 PHE highlighted the need for self-care resources to improve mental health and overall well-being for members experiencing BH conditions. We also encourage caregivers to utilize our Digital BH resource tool, such as myStrength, for their self-care or to better understand the BH diagnosis of the child or family member.

Definition and Description of Service. 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.

Eligible Members. All members 13 years old and older are eligible for this VAS.

Limitations or Restrictions. There are no limitations or restrictions on the usage of our Digital BH Platform.

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.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care contracts with myStrength, a third-party vendor to provide the Digital BH Platform VAS.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters and emails, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access our Digital BH Platform via a link on our public website anytime. Members must create an account on the Digital BH Platform. Care Managers, CHWs, and other member-facing staff may also recommend the resource to members and caregivers.

Identification of the Expanded Benefit in Administrative or Encounter Data. We isolate costs for the Digital BH Platform into a specific cost center and provide information to MLTC in our Administrative Expense Reports.

[7] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/prev_dent_care/state/NE, accessed 7 Jun 2022.

Digital Wellness Support Program

Wellness programs are shown to increase positive health behaviors among participants. Wellness programs provide health education and disease self-management tools. They also can help motivate a person to take charge of their health behaviors. Nebraska Total Care is committed to providing multiple tools for members to improve their health. As a complement to our Digital BH Platform, Krames Health Library, and memberships to Weight Watchers and YMCA, we also offer our Member Digital Wellness Support Program to help motivate positive health behaviors.

Definition and Description of Service. 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.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. Members must create a member account in our member portal to access this VAS.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides this VAS.

How and When Members and Providers Will Be Notified of VAS. We inform members via the Member Handbook, Member Newsletters, and our public website. Care Managers and CHWs also provide information about this benefit when interacting with members. Nebraska Total Care informs providers of the benefit through the Provider Handbook, provider training, and communications including newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members access the Digital Wellness Support Program by logging into the member portal on Nebraska Total Care's website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the Digital Wellness Support Program are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Doula Services (*New VAS)

Nebraska Total Care recognizes that maternal and infant morbidity and mortality is inextricably connected to disparities and inequity in care, especially within the Black, Hispanic, and rural communities. We will combine award-winning experiences from our affiliate health plans across the country with local and state partnerships to reduce maternal and infant health disparities for members. Doulas are an especially important resource for pregnant individuals, who experience adverse health outcomes and racial disparities in maternal and infant health due to systemic racism and discrimination, geographic location, socioeconomic stressors, and cultural barriers to care. For example, our California Medicaid affiliate found that ***members paired with doulas had a 13% increase in prenatal care, a 14% increase in postpartum care, and a 13% decrease in C-section rates compared to members without doulas. Additionally, a birthing parent with doula support was more likely to breastfeed at six months (37% vs. 17%).***

To improve maternal and child outcomes in prenatal, postpartum, and inter-pregnancy care, we will offer local in-person doula services for Omaha Health Equity Neighborhoods. For members outside Omaha, we will offer access to virtual doula services.

Definition and Description of Service. We will partner with Omaha-based doula programs ***for in-person doula services***. Our 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. With the launch of this partnership, we will focus on serving 100 members in Omaha zip codes 68111, 68104, and 68107. Pilot outcomes data, health equity data, and local partnerships will inform where Nebraska Total Care will expand in-person doula services in future contract years. For members outside the pilot area, Nebraska Total Care will offer a ***Virtual Doula Program. We will also incorporate depression and SDOH screening to fully support pregnant members and families***.

Members will have access to certified doulas who support birth parents and their partners throughout the birth journey and lactation consultants for the first year of their child's life as follows:

- Prenatally, doulas guide birth plan creation, refer to appropriate prenatal care, encourage healthy behavior during pregnancy, teach pain management and patient empowerment strategies, and prepare parents for breastfeeding.
- During labor and delivery, doulas are available to maintain or adjust the birth plan, advocate for the birthing parent, and support the birthing parent and partner with comfort and patient empowerment techniques.

- Post-partum doula and lactation consultants work collaboratively to support new parents with physical, emotional, and psychological challenges and consult with new parents on postpartum recovery, infant feeding, newborn care, newborn well visits according to the American Academy of Pediatrics (AAP) Bright Futures™ periodicity schedule, and referrals to other specialists within Nebraska Total Care's provider network.

Advancing Health Equity

In partnership with our national and local doula providers, we are launching a member workforce development program to recruit and bolster Nebraska's doula workforce, particularly focused on creating opportunities for individuals that reflect the membership who are interested in doula careers. This program will help remove SDOH barriers, improve population health and health equity, and promote economic development in Nebraska.

Eligible Members. All pregnant members and members postpartum for up to one year will be eligible for the Doula Services VAS. Up to 100 pregnant members living in the identified Omaha County zip codes will be eligible for in-person the Doula Services VAS. We will expand in-person Doula Services eligibility based on outcomes from the pilot and health equity data in 2023 and beyond.

Limitations or Restrictions. There will be no limitations or restrictions on virtual Doula Services. In-person Doula Services are limited to 100 members in the identified zip codes.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care will contract with local and national partners to provide this VAS.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will also outreach members with NOPs to provide information about this VAS. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members or providers may initiate a request for Doula Services through a Care Manager, CHW, or Member Services Call Center representative.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with Doula Services will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Electric Breast Pumps

Addressing Maternal and Child Health

Nebraska Total Care will support members who choose to breastfeed by providing electric breast pumps. Electric breast pumps are more efficient as they help express milk more quickly than manual pumps. ***In 2021, we provided 1,757 electric double breast pumps to our members to support breastfeeding.*** In response to the current baby formula shortage, we expanded access to breast pumps by enabling them to be requested at any point during pregnancy.

Definition and Description of Service. We will provide an electric breast pump and breast pump kit to any new mother enrolled in Nebraska Total Care.

Eligible Members. All new mothers are eligible. They can ask for a breast pump at any point during pregnancy up to a year post-partum.

Limitations or Restrictions. Members are limited to one electric breast pump every two years. Only one pump is provided for births of multiples, for example, twins, triplets, etc.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's network of durable medical equipment (DME) providers fulfill member orders for electric breast pumps.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also will outreach members with NOPs to provide information about this VAS. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. A provider must prescribe a breast pump. Members can locate a DME provider on our public website using the ***Find-a-Provider*** search feature. They can also order a breast pump by mail from one of our approved DME vendors. We currently contract with Aeroflow, HOME DME, and MEDLINE for breast pumps. If a provider requests the member use a hospital grade pump, the provider can submit a PA request. Our Member Services Call Center staff can assist members in locating a DME provider or with the PA process.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track claims submitted for electric breast pumps. Once claims are adjudicated to a finalized status in our Claims Processing System, costs associated with this VAS are

isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Enhanced Transportation for Pregnant and Parenting Members

Nebraska's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. Each month, Nebraska WIC serves 35,000 people across the State. Maternal WIC participation during pregnancy is likely to be associated with a lower risk of preterm birth and a lower risk of low birth weight infants.[8]

A pregnant member participating in birthing classes can increase their confidence and comfort with the birthing process. Recent research published in the International Journal of Gynecology and Obstetrics indicates that among women with severe fear or anxiety about childbirth, classes designed to prepare mothers for delivery and motherhood are associated with lower rates of cesarean delivery, better chances of breastfeeding, and lower risk of postpartum depression.[9,10]

Definition and Description of Service. Nebraska Total Care provides round trip transportation to birthing classes and WIC appointments to support pregnant and parenting members. Transportation modes are determined according to current guidelines for non-emergency medical transportation.

Eligible Members. Pregnant members attending birthing classes and WIC appointments are eligible. WIC-eligible members, including parents and guardians escorting WIC-enrolled children and breastfeeding members, are also eligible for transportation to WIC clinics.

Limitations or Restrictions. Transportation is limited to WIC appointments and birthing classes. Members need to schedule rides at least three working days before the appointment. Rides may be scheduled up to 60 days in advance of appointments.

Types of Providers Responsible for Providing the VAS. Our non-emergency medical transportation Subcontractor, MTM, provides this VAS.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also outreach members with NOPs to provide information about this VAS. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members access services by calling our Member Services Call Center and choosing the transportation option from the menu. This connects directly to MTM. Members may also use the MTM public website directly to schedule rides, or they can download the MTM Link Member app on their mobile device.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track claims submitted for enhanced transportation by our vendor, MTM. Once claims are adjudicated to a finalized status in our Claims Processing System, costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Findhelp Community Resource Platform

It is well established that SDOH needs are responsible for as much as 40% of a member's health and wellness outcomes. Nebraska Total Care's Findhelp is a social needs referral platform connecting members to local social services and CBOs that help improve member health outcomes, remove barriers to good health, and reduce the overall cost of health care.

Definition and Description of Service. 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 as well as increase the likelihood that members are satisfied with the tool and will continue using it to improve their

[8] "Maternal and Child Outcomes Associated With the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)." *Agency for Healthcare Research and Quality*, 19 Apr 2022. https://effectivehealthcare.ahrq.gov/products/outcomes-nutrition/research.
[9] Ohad Gluck et al." The impact of childbirth education classes on delivery outcome." *International Journal of Gynecology & Obstetrics*, 7 Jan 2020. https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1002/ijgo.13016.
[10] Vishwadha Chander. "Childbirth classes may help first-time mothers have normal deliveries." *Reuters*, 24 Jan 2020. https://www.reuters.com/article/us-health-pregnancy/childbirth-classes-may-help-first-time-mothers-have-normal-deliveries-idUSKBN1ZN2JX.

access to SDOH resources.

When working directly with members, Nebraska Total Care staff can make closed-loop referrals to CBOs. In 2021, we completed 401 closed-loop referrals, verifying member connection to resources and services. This helps us ensure members receive the services they need to support their health.

Eligible Members. All members are eligible for Findhelp.

Limitations or Restrictions. There are no limitations or restrictions for this VAS.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care contracts with Findhelp to provide the searchable database. Findhelp is responsible for validating and updating resources in the database.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations

How Members May Access the VAS. Members, caregivers, and providers access Findhelp through our website, enabling members and their families and caregivers to locate resources at any time. Members may also download the Findhelp app for Apple and Android devices. Members may also call the Member Services Call Center to access resource information by phone.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

The Nebraska Total Care Difference

We were the only MCO to allow access to community resources on a public website during the COVID-19 PHE. In 2021, 1,735 unique users conducted 5,997 searches on Findhelp. We helped Members connect with state and local organizations for:

- Housing and homelessness prevention
- Utility bill assistance
- Emergency rental assistance
- Food assistance
- Cell phone assistance

Friendly Voices Program (*New VAS)

Social isolation and loneliness affect a significant portion of the older adult population. Roughly 25% of people ages 65 and older are considered to be socially isolated in the United States.[11] Loneliness and social isolation are associated with poor health outcomes for adults ages 50 and older, including a 50% increased risk of dementia, a 32% increased risk of stroke, and higher rates of depression, anxiety, and suicide.[12] Social isolation is one of the most prevalent SDOH need identified through our proprietary NEST tool. Nebraska Total Care will help members feeling lonely or socially isolated make social connections to improve their mental and physical well-being through our new Friendly Voices Program.

Definition and Description of Service. Nebraska Total Care's Friendly Voices Program, in partnership with Determined Health Inc. (DHI), will connect local community-based volunteers with members identified as being at risk for social isolation. Friendly Voices is a social isolation solution that puts the focus on direct, interpersonal interactions and connections with members. Friendly Voices' goal 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.

Nebraska Total Care refers members age 50 and older, dual eligible members including DSNP, and individuals identified by Care Management to DHI. We provide DHI with the member's name, preferred communication style, the best time of day for a call, and the member's interest level in receiving a supportive social call. The Friendly Voices community volunteer uses DHI's CallHub platform to call the member and then document the call notes, including date and time, duration, content, and any flags for serious needs discussed or perceived on the call for the Nebraska Total Care team. This solution makes meaningful interpersonal connections and allows for tailored calls to be made to our members.

Eligible Members. All adult members will be eligible for the Friendly Voices Program.

Limitations or Restrictions. There will be no limitations or restrictions for this VAS.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care will partner with DHI to deliver this VAS.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member

[11] "Social Isolation and Loneliness in Older Adults." *National Academies of Sciences, Engineering, and Medicine*, 2020. https://nap.nationalacademies.org/catalog/25663/social-isolation-and-loneliness-in-older-adults-opportunities-for-the.
[12] "Loneliness and Social Isolation Linked to Serious Health Conditions." *Centers for Disease Control and Prevention*, 29, Apr 2021. https://www.cdc.gov/aging/publications/features/lonely-older-adults.html.

Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will provide information about this VAS when interacting with members identified as potentially socially isolated. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations

How Members May Access the VAS. Members will be identified by our Member Services and Care Management teams for participation in Friendly Voices. Members can also request to be enrolled by contacting our Member Services Call Center.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with this VAS will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

GED® Tutoring and Test Prep Kits (*Enhanced VAS)

Educational attainment is a strong predictor of health outcomes. Higher educational attainment is associated with better employment opportunities, higher wages, increased health literacy, fewer chronic conditions, and better self-reported health. In 2019, roughly 8% of Nebraskans ages 25 and older did not have a high school diploma or GED. A health equity issue exists for Nebraskans of color as 36.8% of Hispanic adults and 14% of Black adults did not have a high school diploma in 2019. To address SDOH and improve the health of members, Nebraska Total Care will continue to offer GED support as a VAS and enhance member support with additional tutoring services in the next contract period.

Definition and Description of Service. Nebraska Total Care will provide GED study materials and up to five individual, in-person, or virtual tutoring through Nebraska non-profit community organizations.

Eligible Members. All members between ages 16 and 19 not currently enrolled in high school and over age 18 without a high school diploma will be eligible for GED tutoring and test prep kits.

Limitations or Restrictions. Members will be limited to one set of study materials and five tutoring sessions per year.

Types of Providers Responsible for Providing the VAS. We will partner with local CBOs and virtual partners to provide GED study materials and tutoring sessions for eligible members.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will also provide information about this VAS when interacting with members. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members or providers may initiate a request through a Care Manager, CHW, or Member Services Call Center representative.

Identification of the Expanded Benefit in Administrative or Encounter Data. We will track participation in this VAS through invoices submitted by GED tutoring partners. Costs associated with this VAS will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Interpretation Services at Provider Offices

We believe every member should receive culturally competent and linguistically appropriate care. This means understanding each member's language preference and ensuring they have access to necessary professional interpretation services when interacting with Nebraska Total Care staff as well as with our provider network. Professional interpretation at provider appointments helps improve patient care by ensuring the provider understands the member's medical history and needs. It also helps the member understand the provider's plan of care and any prescriptions or treatments provided. We have provided interpretation services as a VAS for members at provider appointments since 2017 in alignment with MLTC Provider Bulletin No. 17-19 which clarified interpretation service responsibility. ***By providing professional interpretation services, we facilitate equitable access by providing linguistically appropriate care while reducing the provider burden related to locating an interpreter.***

Definition and Description of Service. Nebraska Total Care provides telephonic language interpretation assistance 24/7 via our language line provider, Voiance, which provides interpretation for more than 250 languages. For in-person translation services, we partner with CulturaLink, a minority-owned business entity. CulturaLink staff receives diversity, inclusion, and cultural competence training to effectively communicate with members. We also partner with Translation Station for American Sign Language services at provider offices for members.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. There are no limitations or restrictions on telephonic interpretation services.

Types of Providers Responsible for Providing the VAS. We partner with local and national vendors to deliver interpretation services to our members.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We note all member language and communication needs in TruCare Cloud and our Customer Relations Management platform so our staff is aware of a member's language needs. We inform providers of this VAS through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members or providers may initiate a request for telephonic interpretation services by calling our Member Services Call Center. Our Member Services and Care Management teams arrange for in-person interpretation during a member's health appointments.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with interpretation for members while interacting with providers are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Kits for Children and Youth in Foster Care

Nebraska Total Care realizes the experience of entering a new foster care placement can be difficult for children and youth. Many times, placements occur quickly, and children and youth can lose personal items or not be able to pack a bag. We believe children and youth in foster care deserve to feel a sense of dignity. We seek to provide that dignity by delivering a backpack or duffle bag with personal supplies to ease the transition.

Definition and Description of Service. To help kids in foster care feel comfortable and valued, we provide age-appropriate kits for children and youth in foster care. The kits include a backpack, hygiene supplies, a journal, and educational books and games from Phoebe's Kids Club (a VAS described below).

Eligible Members. All members in foster care are eligible for this VAS.

Limitations or Restrictions. We provide one kit per member when they first enroll with us as a Foster Care member.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care will provide kits.

How and When Members and Providers Will Be Notified of VAS. We inform members via the Member Handbook, Member Newsletters, and our public website. Care Managers and CHWs with specialization in the foster care system also provide information about the benefit when interacting with members in foster care, DHHS social workers, and foster care CBOs. Nebraska Total Care informs providers of the benefit through the Provider Handbook, provider training, and communications including newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members, foster parents, family, and providers can request a kit by contacting our Member Services Call Center, their Care Manager or CHW, or via our website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the kits are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Krames Health Library

Health literacy impacts overall health. People with low health literacy may avoid going to the doctor for easily treatable injuries or conditions. This can cause 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.[13] ***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.***

Definition and Description of Service. Members receive free access to our 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 searchable by topic or keyword and easy to navigate, includes books, health sheets, and a comprehensive drug reference guide. Krames uses health literacy principles to increase readability and comprehension and motivate healthy behaviors. Through Krames, members can learn about wellness, illness, plans of care, medications, and many other helpful tips and facts. Krames is accessible in multiple languages.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. There are no limitations or restrictions on this VAS.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care contracts with Krames, who maintains the

[13] "Talking Points about Health Literacy." *Centers for Disease Control and Prevention*, 21 May 2021. https://www.cdc.gov/healthliteracy/shareinteract/TellOthers.html.

library.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members access the health library anytime via Nebraska Total Care's public website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the health library are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

My Health Pays™ Rewards Program

Nebraska Total Care offers MLTC-approved and OIG Advisory No. 20-08 compliant incentives as part of our My Health Pays Rewards Program to motivate members to encourage healthy behaviors and participation in prevention and wellness activities. Our financial incentives actively promote personal health care responsibility and reward healthy behaviors and adherence to plan of care regimens. From February 2020 to February 2022, the following rewards saw a significant increase in earnings, indicating that members are utilizing preventive services more:

- 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
- 103.7% increase in breast cancer screening
- 110.2% increase in annual PCP visits

Definition and Description of Service. All Nebraska Total Care members are automatically enrolled in My Health Pays. Members earn rewards by completing healthy activities like annual doctor visits, cancer screenings, flu vaccinations, infant well visits, notifying us of a pregnancy, and accessing prenatal and postpartum care. After the first activity is completed, a Visa® Prepaid Card is sent to the member with their reward amount pre-loaded. Members receive a notification when additional rewards have been loaded into their accounts. The account is credited continuously as additional rewards are earned. Rewards can be used for utilities and telecom, groceries, gas, housing support, educational needs, and clothing purchases.

Rewards are earned as described in **Table 19.B.**

Table 19.B – Nebraska Total Care's My Health Pays Rewards Program

Eligible Activity	Reward Amount	Eligibility	Restrictions
Annual Flu Vaccine	$10	Adults 21 and older	One reward per year
Annual Checkup with PCP	$10	Adults 21 and older	One reward per year
Infant Well Visits	$10 per visit ($60 maximum)	Infants up to 15 months	$10 per visit; up to $60 total
Annual Well-child Visit	$10	Children and youth through age 20	One reward per year
HPV Vaccine	$15	Children between ages 11 and 12	Must receive two doses within 12 months
NOP – First Trimester	$15	Pregnant members up to 12 weeks gestation	One reward per pregnancy
NOP – Second Trimester	$10	Pregnant members between 13 and 24 weeks gestation	One reward per pregnancy

Nebraska Experience Matters

Our experience in Nebraska helped us tailor our My Health Pays program to meet MLTC goals and produce meaningful outcomes. We worked with MLTC to adjust our program when we discovered our Health Risk Screening incentive (HRS) was underutilized and the HRS was often incomplete. ***We improved our year-over-year HRS results through direct member contact instead of using an incentive—in 2021, we increased HRS completion by 42.2% over 2020 without the incentive.*** We were able to shift that funding to the NOP incentive to better align with MLTC's maternal and child health goals.

Eligible Activity	Reward Amount	Eligibility	Restrictions
Breast Cancer Screening	$15	Women 40 to 74	One reward every two years
Cervical Cancer Screening	$15	Women 21 to 64	One reward per year

Eligible Members. All members are eligible for the My Health Pays Rewards Program as described in **Table 19.B**.

Limitations or Restrictions. Limitations and restrictions are listed in **Table 19.B.** Funds expire 90 days after the termination of coverage or 365 days after the date the reward was earned, whichever comes first.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides this VAS.

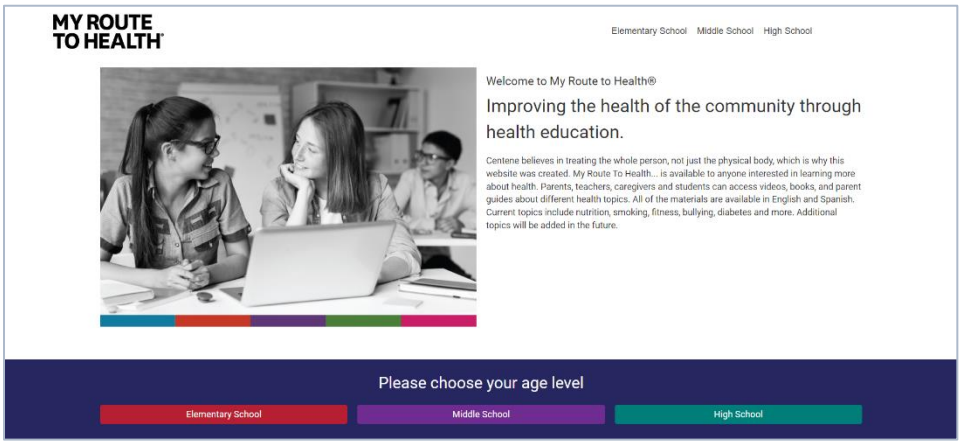
How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members are automatically enrolled in My Health Pays. Rewards are earned when a member completes eligible activities and after claims adjudication.

Identification of the Expanded Benefit in Administrative or Encounter Data. My Health Pays costs are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports. Incentives are allocated to members once claims are adjudicated to a finalized status in our Claims Processing System.

My Route to Health®

Definition and Description of Service. To help support health literacy across Nebraska, Nebraska Total Care offers My Route to Health - a literacy and health education program. The My Route to Health® initiative includes a book series of nearly 80 published books on a diverse range of topics including bullying, dental health, smoking prevention, handwashing, healthy eating, asthma, diabetes, anti-bullying, vision, and dental care, being a foster child, Internet safety, exercise, and other health topics. The My Route to Health program offers educators, parents, students, and their caregivers ready access to health literacy books, plus parent guides, on health topics to increase knowledge and awareness about health while promoting literacy – and health literacy.



Materials are available in English and Spanish, in addition to being written at a fifth-grade reading level or below, with appealing graphic elements. We use a friendly tone, active voice, common words, and short sentences; we provide examples when words might be confusing; and we obtain member feedback to ensure clear messaging. Nebraska Total Care ensures our communication methods are culturally competent, and meet the language, cognitive, and functional needs of members. Books include interactive components and are published for infants, children, teens, parents, and adults.

Most recently, My Route to Health has gone digital with a new website – myroutetohealth.com. This website leverages the same content from the printed materials, delivered online with audio books, digital copies of the books and interactive components for youth. In addition, activity pages are available for educators to download and use with their students. My Routh to Health books and associated activities are designed to help educators deliver quality health education to youth in elementary, middle school, and high school. Through My Route to Health, we aim to improve the health of Nebraska's local communities through health education, chronic disease management, prevention, and awareness – to help children, youth, and families develop a strong foundation for lifelong health.

Eligible Members. All members are eligible for this VAS.

Limitations or Restrictions. There are no limits or restrictions on this VAS.

Types of Providers Responsible for Providing the VAS. My Route to Health is administered by Nebraska Total Care.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members access the VAS via Nebraska Total Care's public website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with the VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

NICU Support Kits

Addressing Maternal and Child Health

Nebraska Total Care's ***Start Smart*** Care Management team supports parents and guardians of members in the NICU with educational resources, such as guides for parenting in the NICU and what to expect in the NICU. We also support members with discharge planning to ensure health gains made in the NICU are sustainable.

Definition and Description of Service. As part of our Start Smart program, the NICU program provides education and support kits for parents or guardians whose infants have been admitted to the NICU. NICU support kits include educational materials on the importance of breastfeeding. We also offer a free electric breast pump and breastfeeding starter kit for moms as well as a supply of diapers. Kits are delivered by a Care Manager or CHW. We also educate on how to access health care services, the importance of selecting a pediatrician and scheduling the baby's well visits, appropriate ED use, available parenting programs, and other services such as smoking cessation, ConnectionsPlus, and transportation benefits.

Eligible Members. All members admitted to the NICU are eligible for this VAS.

Limitations or Restrictions. NICU Support Kits are limited to one per member.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides NICU Support Kits.

How and When Members and Providers Will Be Notified of VAS. We inform members via the Member Handbook, Member Newsletters, and our public website. Care Managers and CHWs with specialization in maternity and NICU services also provide information about the benefit when interacting with members enrolled in Start Smart and when informed of a NICU admittance. Nebraska Total Care informs providers of the benefit through the Provider Handbook, provider training, and communications including newsletters, e-mail, webinars, and orientations.

7% NICU Stay Decrease

Nebraska Total Care's Start Smart program and NICU Support Kits helped reduce NICU average length of stay by 7% between 2018 and 2021.

How Members May Access the VAS. Parents, guardians, caregivers, and providers of members in the NICU can request a Support Kit by contacting our Member Services Call Center, their Care Manager or CHW, or via our website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with NICU Support Kits are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Phoebe's Kids Club

Teaching children about healthy habits through fun, interactive learning opportunities can impact obesity and obesity-related diseases like diabetes, stroke, and heart disease, and may help children have a healthier, longer, and more active life. Nebraska Total Care offers Phoebe's Kids Club, led by Phoebe Frog, to help kids learn about healthy eating and active living and develop lifelong healthy habits.

Definition and Description of Service. Phoebe's Kids Club is an online resource for encouraging healthy eating and active living for Nebraska Total Care members. The Kids Club has downloadable health adventure books, a school year journal, games, coloring sheets, an activity log, and a healthy hip hop downloadable app that promotes movement, mindfulness, and meditation.

Eligible Members. All members are eligible for this VAS. The content is geared for members ages 12 and younger.

Limitations or Restrictions. There are no limitations or restrictions on Phoebe's Kids Club.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides this VAS.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS

when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access this VAS on our public website anytime.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Practice Dental Visits for Members with Special Health Care Needs (*New VAS)

Dental health is essential to overall health and wellbeing. Poor dental health can impact a person's ability to speak, smile, smell, taste, chew, swallow, and make facial expressions to show feelings and emotions in addition to causing painful, disabling, and costly oral diseases and preventing gainful employment. Regular preventive dental care can catch problems early when they are usually easier to treat. But many people do not get the care they need. Data indicate that people with intellectual and developmental disabilities (I/DD) have more untreated cavities and a higher prevalence of gingivitis and other periodontal diseases than the general population. Nebraska Total Care is committed to removing barriers to dental care by offering practice dental visits to members with special health care needs, including I/DD. Practice dental visits allow for the member and caregiver to meet with the dental team, voice preferences and concerns, and understand what happens in a dental appointment in advance of any exams or treatments.

Definition and Description of Service. We will provide members with special health care needs a practice dental visit when they establish with a new dentist. The practice visit will include these best practices:

- Review of medical history by the dentist before practice visit
- Visit the dental office with the full dental team
- Explanation of procedures at a level and in a modality the member can understand
- Provision of simple, concrete dental care instructions
- Discussion of informed consent for procedures including sedation

Eligible Members. All members with special health care needs will be eligible.

Limitations or Restrictions. Members will be limited to one practice visit per year, or when they need to establish care with a new dentist.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's dental network will provide this VAS.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will also provide information about this VAS when interacting with members. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can make practice appointments directly with any Nebraska Total Care dental provider. Members or providers also may initiate a request through a Care Manager, CHW, or Member Services Call Center representative who can assist with finding a dentist and making an appointment.

Identification of the Expanded Benefit in Administrative or Encounter Data. We will track claims submitted for practice dental visits. Once claims are adjudicated to a finalized status in our Claims Processing System, costs are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

In 2020, 21.7% of Nebraska adults reported binge drinking or heavy drinking.[14] Additionally, 10% of Nebraska youth ages 12 to 17 reported drinking alcohol in the past month (2018-2019). Early intervention in BH conditions can help stop or delay more serious BH conditions, including substance use disorder (SUD).

Nebraska Total Care covers SBIRT to support the prevention and early intervention of risky alcohol, substance abuse, and tobacco consumption. SBIRT is an evidence-based, early intervention approach for people with non-dependent substance use before they need more extensive or specialized treatment. SBIRT is offered in primary care centers, EDs, trauma centers, and community health settings.

Definition and Description of Service. Nebraska Total Care's comprehensive SBIRT VAS includes the following characteristics:

[14] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/NE, accessed 7 Jun 2022.

- It is brief (typically about 5 to 10 minutes for brief interventions and 5 to 12 sessions for brief treatments).
- The screening is universal.
- One or more specific behaviors related to risky alcohol and drug use are targeted.
- The services occur in a non-substance abuse treatment setting.
- It is comprehensive (comprised of screening, brief intervention/treatment, and referral to treatment).

Eligible Members. All members are eligible for SBIRT services.

Limitations or Restrictions. There are no limitations or restrictions on SBIRT for members.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's provider network of PCPs and other non-SUD providers screen members at their discretion.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs may also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access services at their PCP or other providers. Members can call the Member Services Call Center for assistance locating a provider, or they may use the Find-a-Provider feature on our public website.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track claims submitted for SBIRT. Once claims are adjudicated to a finalized status in our Claims Processing System, costs are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Sickle Cell Disease (SCD) Comfort Kits

Black people living with SCD disproportionately experience challenges with access, quality, and affordability of care. Black patients with SCD may encounter racial discrimination when seeking treatment for acute pain crises. Some health care providers may inaccurately perceive SCD patients as drug-seekers and may doubt their severity of pain, causing extended ED wait times and difficulty filling pain medication prescriptions. Additionally, there are a limited number of providers trained and willing to treat people with SCD and access is more restricted when a patient with SCD is a Medicaid beneficiary. These issues result in a 30-year gap in life expectancy for people with SCD than for people without SCD.[15]

Nebraska Total Care's SCD program improves the health and quality of life of members with SCD by engaging with members to develop and improve disease self-management strategies, connecting them to a PCP who can help manage SCD, and removing barriers to care, for example, finding a PCP or specialist, removing transportation barriers, and addressing SDOH needs. As a result of our SCD program, Nebraska Total Care realized these outcomes:

- From 2017 to 2021, we increased participation in Care Management for members with SCD by more than 12 percentage points. We achieved higher levels of Care Management over time, even during the pandemic.
- From 2017 to 2021, inpatient (IP) utilization rates for SCD-related events decreased. This included a 22% reduction in IP utilization before the pandemic.
- From 2017 to 2020, there was a 16.8 percentage point increase in members with an SCD assessment, allowing for early intervention by Care Management.
- From 2017 to 2020, there was a 38% increase in PMPM spend for hydroxyurea fills for members with SCD, indicating that our program is effective in helping members gain access to relevant SCD medications.

Definition and Description of Service. As a VAS to our SCD program, Nebraska Total Care provides an SCD kit to eligible members. The SCD kit contains our Living Well with Sickle Cell book, SCD educational literature, a hot and cold therapy pack, a water bottle, pain bracelets, and a thermometer. These items help soothe pain during an exacerbation of symptoms.

Eligible Members. Members with an SCD diagnosis are eligible.

Limitations or Restrictions. Members are limited to one SCD kit.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care is responsible for providing SCD kits.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when outreaching members with SCD for Care Management. We inform providers through the Provider Handbook, during

[15] "Sickle Cell Disease Health Disparities." CDC Foundation. https://www.cdcfoundation.org/sites/default/files/files/SickleCellDisease-HealthDisparities-FactSheet021618.pdf. Accessed 8 Jun 2022.

provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access this VAS through their Care Manager.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with SCD kits are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Sports and Camp Physicals

Playing sports and attending camps are great ways for children and youth to increase physical fitness and develop social skills. Sports and camp physicals help tell if it is safe for a child to participate in certain activities and serve as a companion to regular well-child checks. The Nebraska School Activities Association requires that a physical evaluation be completed each year before a student can participate in sports. Nebraska Total Care offers sports and camp physicals to encourage members to participate in healthy activities and remove barriers to sports and camp participation for families.

Definition and Description of Service. Sports and camp physicals include a medical history and a physical exam. The physical exam checks:

- Height, weight, and blood pressure measurements
- Vision
- The heart and lungs to detect abnormalities
- The musculoskeletal system to check for range of motion and the integrity of joints

Eligible Members. Members ages 4 to 18 are eligible.

Limitations or Restrictions. Nebraska Total Care covers one sports or camp physical per eligible member per year.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's PCP network provides this VAS.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can schedule a sports or camp physical directly with their PCP. Members can call our Member Services Call Center for help finding a PCP. They can also use our public website's Find-a-Provider feature to locate a PCP.

Identification of the Expanded Benefit in Administrative or Encounter Data. Once sports and camp physicals claims are adjudicated to a finalized status in our Claims Processing System, costs are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Start Smart for Your Baby® Pregnancy Support Items (*Enhanced VAS)

Start Smart is Nebraska Total Care's program for pregnant women and new moms. It is designed to customize services and care for a healthy pregnancy and baby. Start Smart includes Care Management provided by nurses, therapists, and licensed social workers for members who need extra support. ***As a result of member outreach following receipt of a NOP, Nebraska Total Care members increased utilization of prenatal care by 15.1% between 2018 and 2021. Prenatal care visits increased by 17.0% for Black members and 13.4% for Hispanic members.***

As part of Start Smart, Nebraska Total Care supports SDOH needs and promotes prenatal and postpartum care, by offering a choice of one item from the list below with completion of a NOP at least 60 days before their expected due date:

- Infant car seat
- Portable crib, for example, Pack 'N Play
- Stroller
- Postpartum meal delivery

Extra Support for 'Dineshee' and Baby. During a prenatal visit, a screening indicated Dineshee's baby had a congenital heart defect and Turner's Syndrome, a rare chromosomal disorder. Throughout her pregnancy, our Start Smart Care Manager (CM) was there to help explain medical procedures, coordinate Dineshee's prenatal appointments, and provide ongoing emotional support. Our CM also helped Dineshee find stable housing as Dineshee had been experiencing homelessness over the last several months. This extra support allowed Dineshee to focus on planning for her baby's care needs and developmental milestones. Of her CM, Dineshee says, "She is amazing! She thinks of me as a person and cares about more than just my health."

Definition and Description of Service. Nebraska Total Care's Care Management team immediately outreach pregnant members upon receipt of the NOP. Members are informed about our Start Smart program and pregnancy support items during outreach. Care Management staff arrange for the car seat, portable crib, or stroller to be shipped to the member. The Care Manager begins to establish a relationship with the member during this outreach to encourage participation in prenatal and postpartum care.

For members who select postpartum meal delivery, 10 freshly prepared, medically tailored meals will be drop-shipped to the member's home after discharge from the hospital. A Care Manager will work with the member during their inpatient stay to arrange for meal delivery.

Eligible Members. All pregnant members are eligible for Start Smart. To receive pregnancy support items, members must submit a completed NOP form at least 60 days before delivery. Members do not need to be enrolled in Start Smart to receive a support item.

Limitations or Restrictions. Members are limited to one support item per NOP.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides car seats, strollers, and portable cribs. We will work with two national vendors, Mom's Meals and GA Foods, to provide nutritionally tailored postpartum meals.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members at community baby showers or other events. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can submit a NOP by calling our Member Services Call Center, completing the form via their member portal account, or mailing a printed form to our Omaha address listed on the public website.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with pregnancy support items will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Supermarket Pharmacy Diabetes Program (*New VAS)

Pharmacists and dieticians play an important role in helping people manage diabetes. Pharmacists can assess a patient's health status, provide health education and counseling about glucose monitoring to support diabetes self-management, and refer a person to their PCP or Care Manager for additional support. Dietitians co-located within grocery store pharmacies can provide nutritional counseling and education to people as well as help navigate the store to shop for healthy foods that support diabetes care and fit their food budget.

Nebraska Total Care will partner with Hy-Vee to implement the Supermarket Pharmacy Diabetes Program at select Hy-Vee locations beginning in 2023. Our clinical team will provide diabetes care training and partner with Hy-Vee pharmacy and dietitian teams to support member diabetes management through a holistic approach combining medication management, health education, and nutritional counseling.

Definition and Description of Service. Nebraska Total Care will partner with Hy-Vee pharmacy teams that have co-located dietitians to provide these services to members:

- Hy-Vee pharmacists will provide medication adherence and medication management education to members.
- Pharmacists will help close care gaps by conducting HbA1c testing or other point-of-care tests/screenings.
- Pharmacists will contact prescribers regarding inappropriate or potentially harmful drug combinations, and work with the prescriber to prescribe medications aligned with the member's condition and current medication regimen.
- For members whose food insecurity or food choices impact their diabetes, dietitians will provide education and nutritional counseling, which may include personalized in-store navigation to support healthy food shopping and choices.

Eligible Members. All members with a diabetes diagnosis are eligible for this program.

Limitations or Restrictions. There are no limits on participation in the program. Members are restricted to participating Hy-Vee locations.

Types of Providers Responsible for Providing the VAS. Hy-Vee pharmacists and dietitians will provide this VAS.

How and When Members and Providers Will Be Notified of VAS. Members will be informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs will also provide information about this VAS when interacting with members. We will inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members may self-refer by going directly to a participating Hy-Vee location and showing their Nebraska Total Care member ID card. Hy-Vee pharmacists and dietitians may also engage with members

during prescription fills or other events at Hy-Vee stores.

Identification of the Expanded Benefit in Administrative or Encounter Data. **We will track participation in this VAS through claims information submitted by Hy-Vee. VAS costs will be isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.**

Value Add Drug List

Nebraska Total Care is committed to providing appropriate, high-quality, and cost-effective drug therapy to all Nebraska Total Care members. ***The Nebraska Total Care Value Add formulary is provided as a supplemental benefit to expand the list of covered products beyond the State Preferred Drug List (PDL), such as those drug classes not included on the PDL, and to increase member access to over-the-counter (OTC), prescription, and specialty medications. Our Value Add Drug List also reduces provider administrative burden when requesting non-formulary exceptions.*** For example, the antipsychotic, antidepressant, and anticonvulsant drug classes that are carved out of the State PDL are covered on the Nebraska Total Care Value Add Drug List. Coverage of these drugs on the Value Add formulary increases member adherence to BH medications, which may prevent relapse and decrease inpatient hospitalization.

We also support MLTC's Medicaid Drug Rebate Program by only adding drugs to our Value Add formulary with existing rebate eligible National Drug Codes.

"Nebraska Total Care has been a great partner in taking care of my patients…the Pharmacy team is easily accessible for any questions. Nebraska Total Care 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

Definition and Description of Service. Members must have a prescription from a provider and use a network pharmacy to access this VAS. Our Value Add Drug List is available on our website and lists any limitations or restrictions, including when a PA is required. Drugs may have prescribing limitations for certain ages or certain amounts. We follow the State Summary of Drug Limitations and U.S. Food and Drug Administration (FDA) guidelines for age and amount limitations.

A team of doctors and pharmacists from Nebraska Total Care and our parent company meet regularly to choose which drugs should be on the Nebraska Total Care Value Add Drug List. The team reviews new and existing drugs and chooses drugs that work best and are safe. ***Nebraska Total Care's Value Add Drug List currently gives members access to more than 5,000 additional drug options not included on the PDL.*** **Table 19.C** depicts our currently available Value Add Drugs.

Table 19.C Nebraska Total Care's 5,000+ Value Add Drug List by Type or Health Condition

- ADHD medicines
- Alternative medicines
- Analgesics for pain, swelling, muscle, and joint conditions
- Antacids
- Antianginal agents
- Antianxiety agents
- Antiasthmatic and bronchodilator agents
- Antibody drugs to treat low immune system
- Antidepressants
- Antidiarrheals
- Antihistamines
- Antimalarials
- Antimyasthenic/cholinergic agents
- Antipsychotics/antimanic agents
- Antiseptics and disinfectants
- Antivirals
- Blood thinners
- Diagnostic products
- Digestive aids
- Drugs for abnormal heart rhythms
- Drugs to prevent/control uterine bleeding
- Drugs to regulate blood sugar
- Drugs to relax/paralyze muscles
- Drugs to treat blood disorders
- Drugs to treat bowel, intestine, and stomach conditions
- Drugs to treat cancer
- Drugs to treat heart, blood pressure, and circulation conditions
- Drugs to treat heart failure and abnormal heart rhythm
- Drugs to treat lung conditions
- Drugs to treat miscellaneous bladder spasms
- Drugs to treat nausea and
- High blood pressure medicines
- Hormone replacement drugs
- Laxatives
- Medical devices and supplies (e.g., blood pressure, diabetes)
- Medicines for bacterial infections
- Minerals and electrolytes
- Mouth, throat, and dental agents
- Multivitamins and vitamins
- Nasal agents
- Nutrients
- Ophthalmic agents
- Opioid antidotes and antagonists
- Otic (ear) agents
- Psychotherapeutic and neurological agents
- Rectal drugs for pain, swelling, and itching
- Sleeping and eating disorders medicines
- Thyroid agents

Table 19.C Nebraska Total Care's 5,000+ Value Add Drug List by Type or Health Condition		
• Contraceptives • Corticosteroids • Cough, cold, and allergy medicines • Dermatological products	vomiting • Drugs to treat reproductive organs and urinary system • Drugs to treat seizures • Gastrointestinal agents	• Tuberculosis drugs • Ulcer drugs • Vaccines • Vaginal products

Eligible Members. All are eligible for this VAS.

Limitations or Restrictions. We list the specific limitations and restrictions for each Value Add Drug on the pharmacy page of our website. The Value Add Drug List is updated monthly, including limitations or restrictions. A provider can ask for an exception to our rules for drug coverage limits, including:

- A prescribing provider can ask us to cover a drug even if it is not on the drug list
- A prescribing provider can ask us to make an exception for limits on a drug

To request an exception, the provider faxes a PA form to Nebraska Total Care. We make our decision within one business day and communicate back with the provider.

We exclude these drugs from coverage:

- Drugs that do not have FDA approval
- Drugs that are being tested but not approved yet
- Drugs to help a member become pregnant
- Drugs used for weight loss
- Cosmetic or hair-growth drugs
- Drugs used to treat sexual issues

Types of Providers Responsible for Providing the VAS. Nebraska Total Care's network of pharmacies provides this benefit.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations. MLTC's PDL and our Value Add Drug List are available for review by members and providers on Nebraska Total Care's website.

How Members May Access the VAS. Any Nebraska Total Care network pharmacy can fill a Value Add Drug List prescription, including for specialty products. Members can call the Member Services Call Center for help locating a pharmacy or they can use the Find-a-Provider feature on our website.

Identification of the Expanded Benefit in Administrative or Encounter Data. We track all claims submitted for Value Add Drugs. Once claims are adjudicated to a finalized status in our Claims Processing System, costs associated with this VAS are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Weight Watchers

Nationally and in Nebraska, the percentage of overweight and obese adults and children is on the rise. Adults who have obesity are at an increased risk for developing hypertension, diabetes, heart disease, stroke, and mental illnesses such as depression and anxiety. For youth, overweight or obesity in childhood is associated with physical, social, and psychological health issues during adolescence and adulthood. In 2020, 34% of Nebraska adults had a body mass index (BMI) of 30 or greater (obese).[16] For youth, 28% of Nebraska children ages 10 to 17 years reported being overweight or obese for their age in 2019-2020.[17]

Nebraska Total Care's comprehensive weight management program includes education and health coaching for the adoption of healthy lifestyles. As a VAS for members in our weight management program, we offer access to online Weight Watchers to help members increase physical activity, increase healthy food consumption, and increase visits with their PCP. ***In 2021, we provided 139 Weight Watchers memberships.***

Definition and Description of Service. Weight Watchers allows members to create individualized weight loss programs that support weight loss of one to two pounds per week. Weight Watchers allows members to eat foods they love while

[16] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/NE, accessed 7 Jun 2022.
[17] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/youth_overweight/state/NE, accessed 7 Jun 2022.

integrating healthy foods and increased physical activity into their daily routines. Weight Watchers provides a dedicated coach and encouragement for members to make incremental, sustainable behavior changes. Nebraska Total Care offers members a three-month online membership to help them kick start their weight management goals.

Eligible Members. To be eligible, members must be enrolled in Care Management and:

- Have a BMI of 25 or higher for children ages 12 to 16
- Have a BMI of 30 or higher for members ages 17 and older

The member's provider must submit a note by fax or mail confirming BMI (within the previous 30 days).

Limitations or Restrictions. Weight Watchers online memberships are provided in three-month increments. Extensions will be provided for members who demonstrate progress with a decreased BMI greater than one point. BMI must be validated by the member's provider. We will keep extending enrollment until a member reaches the BMI limitations above. Member must be continuously enrolled in Care Management.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides participating members with vouchers for online Weight Watchers. Weight Watchers provides the VAS.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access this VAS through their Care Manager. Members interested in Care Management and Weight Watchers vouchers can contact our Member Services Call Center for more information about both programs.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with Weight Watchers are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

Helping 'Jessica' Live a Healthier Life. Member Jessica has a history of joint pain and wanted help living a healthier life. In December 2021, she called Nebraska Total Care for help. As part of our value-added benefits, we connected Jessica with her local YMCA and provided her with a voucher for Weight Watchers. We also offered Jessica access to our Weight Management programs for help establishing healthy behaviors and losing weight. By May 2022, Jessica had lost 20 pounds through a combination of participation in our Weight Management program, Weight Watchers, and the YMCA. Jessica states her joint pain has noticeably decreased, she feels healthier both physically and mentally, and she has more energy to take better care of her kids.

YMCA Membership

In 2021, Nebraska Total Care provided 3,126 YMCA memberships to help members increase physical activity. Increased physical activity has a positive impact on health outcomes. For adults, regular physical activity (at least 150 minutes a week) is associated with a reduced risk of cardiovascular diseases hypertension, type 2 diabetes, dementia, anxiety, depression, and certain cancers, including bladder, breast, and colon cancer. For children, increased physical activity is associated with improved bone health, weight status, cardiovascular and muscular fitness, cardiometabolic health, cognition, and reduced risk of depression. Children who engage in regular physical activity are also more likely to become physically active adults. In 2020, 21.5% of Nebraska adults reported doing no physical activity or exercise other than their regular job in the past 30 days.[18] For youth, 23.7% of Nebraska children ages 6 to 17 years were physically active at least 60 minutes every day in the past week (2019-2020).[19]

Nebraska Total Care is committed to helping members access resources that support active living. We partner with Nebraska YMCAs to offer this VAS to our members. We also partner with the Alliance Recreation Center to cover memberships.

Definition and Description of Service. Nebraska Total Care provides one three-month YMCA membership per member. YMCA memberships provide access to wellness centers, group fitness classes, on-site child supervision, a new member wellness appointment, and discounted pricing on youth programs, for example, swimming. Members can access any YMCA

[18] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation*, https://www.americashealthrankings.org/explore/annual/measure/Sedentary/state/NE, accessed 7 Jun 2022.
[19] America's Health Rankings analysis of America's Health Rankings composite measure, *United Health Foundation,* https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/physical_activity_children/state/NE, accessed 7 Jun 2022.

across the United States. Members can also access before and after school programs, which accept DHHS child care subsidies.

Eligible Members. Members ages 12 and older are eligible for the VAS.

Limitations or Restrictions. Members are limited to one three-month membership. Extensions may be provided in three-month increments for members enrolled in Care Management and/or who provide a doctor's note.

Types of Providers Responsible for Providing the VAS. Nebraska Total Care provides this benefit through its partnerships with Nebraska YMCAs and the Alliance Recreation Center.

How and When Members and Providers Will Be Notified of VAS. Members are informed through the Member Handbook, in Member Newsletters, and via our public website. Care Managers and CHWs also provide information about this VAS when interacting with members. We inform providers through the Provider Handbook, during provider training, and through newsletters, e-mail, webinars, and orientations.

How Members May Access the VAS. Members can access this VAS through our Member Services Call Center or Care Management staff. Members may also go directly to their YMCA and work with their membership staff to access this VAS.

Identification of the Expanded Benefit in Administrative or Encounter Data. Costs associated with YMCA memberships are isolated into a specific cost center and provided to MLTC in our Administrative Expense Reports.

"I chose Nebraska Total Care because of the YMCA benefit. Obesity runs in my family and being 300 pounds was a wake-up call. I am working with a Care Manager at Nebraska Total Care and taking charge of my health. My execise classes have helped me lose 59 pounds, tone my arms, and strengthen my legs."

- Rhonda (see Rhonda's story at https://www.nebraskatotalcare.com/about-us/testimonial-videos.html)

20. Describe the Bidder's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the Bidder's system for tracking each member's screening, diagnosis, and treatment to ensure services are delivered within the established timeframes. ***Page Limit: 4***

Approach to Member Education and Outreach Regarding EPSDT

As a long-serving managed care organization (MCO), Nebraska Total Care's expertise, systems, and partnerships enable us to exceed requirements and promote innovations to address the underutilization of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Designed to improve health outcomes and ensure health equity statewide, our approach is to educate and encourage all Nebraskans to engage in timely well-child visits, developmental screenings, immunizations, lead screening, dental care, and follow-up care. We will continue providing EPSDT services according to Scope of Work Section V.E.13, all Federal and State requirements, and American Academy of Pediatrics recommendations. Our comprehensive EPSDT approach includes a multi-faceted member engagement strategy; data collection to track member screenings, immunizations, diagnoses, and appointment compliance; and monitoring treatment and outcomes.

Dedicated Staff Focused on EPSDT. Susan Jeffrey, who has ***served as our Maternal Child Health (MCH)/EPSDT Coordinator for the past six years***, will continue to perform her responsibilities to lead Nebraska Total Care's EPSDT program. This role includes:

- Oversight of the EPSDT Plan
- Designing and implementing innovations with support from across our organization to ensure members receive necessary EPSDT services
- Promoting preventive health strategies
- Designing programs to ensure that pregnant members receive maternal and postpartum care
- Identifying and meeting members' needs specific to maternal/child health and EPSDT
- Engaging with community partners to enhance our EPSDT Plan

Table 20.A EPSDT HEDIS Improvements Since MY 2018.

HEDIS Measure	Increase
AAB – Avoidance of Antibiotic Treatment for Acute Bronchitis	*+33.42**
PPC – Postpartum Care	*+14.13*
W15 – Well-Child Visits in the First 15 Months of Life, six or more visits	*+11.89*
IMA – Adolescent Immunization: Combo 2	*+10.22*
CIS – Childhood Immunization Status: Combo 10	*+9.74*
ADD – Continuation and Maintenance follow-up visits after initiation of ADHD medications	*+7.03*
WCC – Weight Assessment for Children/Adolescents –Counseling Physical Activity Total	*+7.54*
AMR – Asthma Medication Ration, ages 12-18	*+4.71**
PPC – Prenatal Care timeliness	*+4.41*
LSC – Lead Screening in Children	*+3.76*
ADD – Initiation phase_ follow-up visits after initiation of ADHD medications	*+3.52*
AMR – Asthma Medication Ratio, ages 5-11	*+3.31**
CWP – A Appropriate Testing for Pharyngitis, Total	*+3.28**
URI – Appropriate Treatment for Upper Respiratory Infection, 3 months-17 years	*+2.19**
AWC – Adolescent Well–Care Visits	*+1.47**
W34 – Well-Child Visits in the Third, Fourth Years in Life	*+0.73*

****Statistically significant increase***

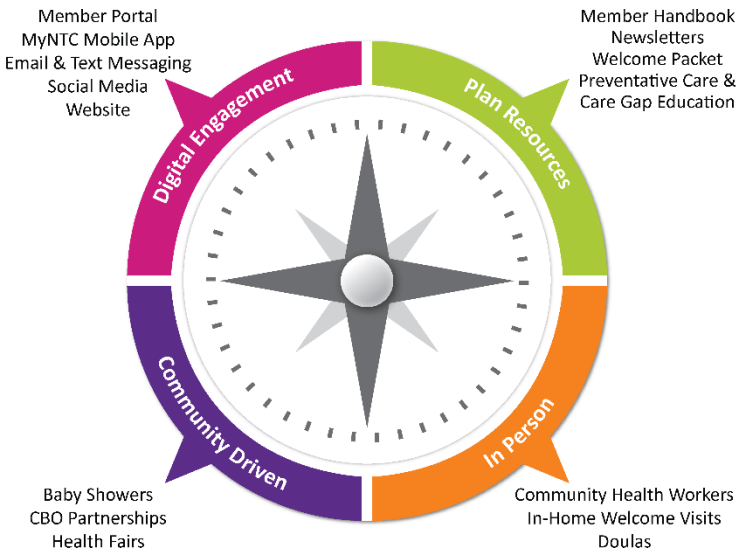
Multi-Faceted Member Engagement in EPSDT Education. As described in detail in response to Question 30 and illustrated in **Figure 20.A**, our Member Care Compass guides member education and outreach activities, including for EPSDT. Through the community partnerships and innovative programming, we create educational materials and opportunities that meet members where they are. We begin educating members and caregivers about the availability and importance of EPSDT services upon enrollment, birth, and through our award-winning **Start Smart for Your Baby® (Start Smart)** program as a part of prenatal care. We share information by phone during orientation from our Member Engagement Team, in the Welcome Packet, in the Member Handbook, and via our website.

We conduct targeted outreach based on individual gaps in care using email, phone calls, and text messaging. Members and providers can view member care gaps through our secure web portals. Our Member Services Call Center and Care Management staff help members and their caregivers schedule appointments and offer solutions to common barriers, such as transportation or choosing a provider. Care Management staff provide Neonatal Intensive Care Unit (NICU) kits to all mothers with babies in intensive care and assure them of our support. We use written material to increase awareness,

education, and adherence to the EPSDT periodicity schedule, including Member Newsletters, social media, brochures, and well-child checkup magnets.

Assessing Parent Understanding of the Importance of EPSDT Services. We assess parents' understanding of EPSDT services and how to access them with each contact. Our Care Managers are trained in Motivational Interviewing to foster trust and help members make positive behavior changes. We always seek the member's points of view and honor their autonomy. We use a person-centered "teach-back" method during every interaction so the Care Manager can assess understanding of the care need and provider education at the member's level. Staff document the assessment in the member's record along with any barriers to care and interventions provided. We track barriers and work with our community partners and Social Determinants of Health (SDOH) supports to implement appropriate solutions.

Figure 20.A Our Member Care Compass guides member education and outreach activities, including for EPSDT.



Community Partnerships. Our Community Engagement Team participates in health fairs and other community-based events across the State to educate and outreach to members about required EPSDT screenings, immunizations, and preventive services. ***Since 2019, this team has participated in 192 health fairs and community-based events related to children's health throughout Nebraska.*** We educate at schools, early childhood centers, community baby showers, YMCAs, and community centers. Partnerships include:

- **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).** Before the COVID-19 Public Health Emergency, we were regularly in WIC clinics to provide member education and connect them to Care Management. When the in-person engagement was no longer possible, Buffalo County WIC looked for a way to ensure their clients could still access all the information they would get from in-person meetings. That propelled us to create ***recorded presentations sent directly to WIC recipients and members and posted on our website for on-demand viewing by anyone***. Topics include Baby Behaviors 0-12 Months, Prenatal Visits, Well-Child Checkups, Breastfeeding Support, WIC Food Packages, and Family Planning. We also email a video series link directly to pregnant members.
- **Pfizer.** We partner with Pfizer to offer Childhood Immunizations and Annual Wellness programs that close member gaps. Members receive a mailer and/or SMS text to communicate that they missed a vaccine shot and/or have an upcoming well-visit. Members who miss vaccines at six months old receive this outreach at nine months old.
- **University of Nebraska Medical Center (UNMC) and Other MCOs.** Nebraska Total Care is partnering with UNMC and other MCOs on the ***Trusted Voices Campaign*** to educate the community about service needs, including vaccinations, preventive care, and screenings. UNMC uses MCO data to identify and determine the reason for delayed or absent preventive care. Together, we select target populations and develop solutions to increase awareness.
- **Children's Hospital and Medical Center (CHMC).** Nebraska Total Care has partnered with CHMC to support their ***craniofacial program*** that specializes in evaluating, diagnosing, and treating infants with an abnormal head shape. If children with moderate to severe cases of plagiocephaly are not appropriately treated, it can result in issues related to functional vision impairments, middle ear infections, feeding issues, migraines, and associated neurodevelopmental delays. Per EPSDT criteria, we consider treatment interventions that improve our member's conditions and make any impairments more tolerable to support optimal development and health.

Innovative Mechanisms to Enhance EPSDT Education and Outreach

Nebraska Total Care continually develops innovations to enhance our education and outreach to members and their families on preventive care and EPSDT. Examples include:

> "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 Community Health Workers, Nebraska Total Care's focus on member benefit is unwavering. It is my experience that this commitment is genuine."
>
> *- Kelley Weiler, JD, Children's Hospital and Medical Center*

Start Smart for Your Baby. Our Start Smart program promotes maternal and newborn health, including those essential visits in the first few months of life. Start Smart's multi-faceted approach to improving prenatal and postpartum care includes enhanced member outreach and education to extend the gestational period and reduce pregnancy complications, premature delivery, low birth weight, and infant disease. Every member enrolled in Start Smart receives clinically informed health education materials promoting prenatal care, postpartum care, newborn care, and healthy lifestyle habits. Through Start Smart, new mothers receive The ***Mother's Guide to Life after Delivery***, which contains information on how to care for their newborn, including completing well-child visits and vaccinations. ***Members who complete the Notification of Pregnancy (NOP) 60 days before their due date in alignment with MLTC's target date for PCP selection can choose a Valued Added Service - a car seat, pack 'n play, stroller, or meal delivery plan.*** As part of the program, we contact members 60 days ahead of the due date, creating the opportunity to assist members in choosing a Primary Care Provider (PCP) for the child ahead of delivery. We support the member through the process of establishing a relationship with their baby's PCP, ensuring early care after birth.

We meet with organizations statewide that support members to share our Start Smart program, educate on the NOP, and build a relationship that addresses Social Determinants of Health collaboratively. For example, in 2021, Hastings Healthy Beginnings identified a need for simplified access to resources for expecting parents. Using our experience in other communities, we sponsored and collaborated on the creation of an annual community baby shower. While the event targets the community's health, it also allows Nebraska Total Care the opportunity to connect directly with our members to complete an NOP and understand Start Smart and EPSDT resources.

Dental Preventive Care. Nebraska Total Care will use outbound phone messaging, emails, and texts to educate and remind members and their families about annual preventive and EPSDT needs, including the need for sealants and varnishes. We will provide increased outreach for members ages 3-18 who have not seen a dentist in the previous 12 months and send a dental care kit that includes a spin toothbrush, fluoride toothpaste, educational resources, and a list of nearby dentists.

Virtual PCP Program to Address Equity in EPSDT Access. We are piloting the ***Babylon 360 Virtual PCP program (Babylon 360)***, an innovative program to address member health disparities, increase access, and advance health equity in rural and frontier counties. 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. While EPSDT is not done through telehealth, Babylon 360 has high engagement with children ages 15-20, demonstrating the effectiveness of technology to engage youth transitions to adult services.

Member Incentives. To further encourage participation in EPSDT services, we offer member incentives through our My Health Pays® rewards program. Members/caregivers earn rewards that can be used on essentials such as food, clothing, transportation, utilities, childcare services, education, and rent. ***From 2020 to 2021, our My Health Pays rewards program saw a 26% increase in payouts to members, indicating higher utilization of preventive services.***

Data System for Tracking Member's Screening, Diagnosis, and Treatment and Reducing Health Disparities

Our sophisticated data management, analysis, and reporting capabilities allow us to track and monitor EPSDT services efficiently. At least quarterly, we complete a total abstraction of member data from our HEDIS data platform to confirm the accuracy of vaccination data. Our Centelligence reporting and analytics platform allows us to track, monitor, and report on EPSDT services. Using this data, we stratify utilization by demographics, including geography, age, sex, race, ethnicity, and

language to identify potential inequities in service delivery. Our Health Equity and Diversity Committee analyzes finalized EPSDT and immunization outcomes to identify new and previously unidentified disparities for action planning. The Committee works with our internal team to develop targeted interventions that increase access to EPSDT services for all members.

Reminders and Follow-Up for Members in Need of Gap Closure. Data from the Centelligence reporting and analytics platform identifies members past due for services and feeds into our integrated Care Management platform, TruCare Cloud, and our Customer Relationship Management platform (CRM), prompting all member-facing staff to engage the member during any call or in-person contact with a reminder to offer to assist with scheduling services. Member Services facilitates a three-way call between the member or member's parent and provider to schedule care and close care gaps. Members can access care gap alerts via our secure Member Portal or our MyNTC Member Mobile App. MyNTC allows direct calling to the provider to schedule needed appointments and direct call to Nebraska Total Care for assistance. All member-facing staff are trained to engage members with care gaps while identifying and addressing language, cultural, and other barriers. We partner with Best Foot Forward which uses extensive search tools to locate members who are hard to reach and have care gaps to engage them in care. This partnership places special emphasis on pregnant and potentially pregnant members and those for whom SDOH appear to be impacting their access to preventive care. ***Best Foot Forward has demonstrated a 58% successful engagement rate for hard-to-reach members in one of Nebraska Total Care's affiliate market.***

Provider Engagement in Care Gap Closure. Through our secure Provider Portal, providers can access a consolidated list that reflects HEDIS-related care gaps for members on their provider roster, including all EPSDT services recommended during a member's next visit. This information prompts the provider to engage the member to close care gaps. Additionally, we incentivize providers to close care gaps through our innovative, individualized contracting models.

Identifying Members who Require Referral and Follow-Up Services. We educate all providers on using claim modifiers that indicate the need for a referral. Coding guidance is detailed in our Provider Billing and HEDIS Guide, which is reviewed and updated at least annually. We reimburse providers for using z-codes to notify us of members' SDOH needs. Providers can refer members for Care Management through the Provider Portal for additional care coordination. For children with special health care needs or those already in Care Management, the member's Care Manager tracks and coordinates all referrals and follow-up services resulting from EPSDT-related screenings. Care Management staff monitor member status to identify new diagnoses that require a plan of care revision, such as disease management, Behavioral Health Services, or SDOH support. We conduct annual compliance audits to ensure that PCPs conducting screenings identify and refer members who need treatment services, including identifying those needing BH treatment.

Monitoring Treatment and Related Health Outcomes. Our MCH/EPSDT Coordinator and Quality staff coordinate and track EPSDT outreach with our member engagement team. We collect input from our Member and Provider Advisory Committees, satisfaction survey results, and member grievance and provider complaint data and analyze this data for trends and improvement opportunities. Supported by Centelligence, our EPSDT, Care Management, and Quality staff use actionable reporting to monitor intervention activities, determine focus areas, and assess results. Staff can view EPSDT compliance and identify care gaps to create data-driven, member-centric strategies aimed at improving health outcomes. ***Reports identify high-performing providers so the EPSDT Coordinator can review initiatives and disseminate local best practices.*** A component of Centelligence is our use of industry-leading and NCQA-certified 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. This enables us to deliver member-level data to pediatricians, equipping them to address emerging health issues at the earliest clinically appropriate time.

21. Describe the Bidder's plan to utilize telehealth for any services in the benefits package, including how the MCO will incorporate member preference for in-person or telehealth service, how it will be operationalized throughout the state, and how its use relates to the Bidder's utilization management strategies. ***Page Limit: 3***

Utilizing Telehealth for Any Services in the Benefits Package

Nebraska Total Care is expanding access to health services for members statewide through a multi-pronged telehealth approach, featuring local partnerships and national solutions informed by our parent company's long-standing, far-reaching Medicaid telehealth offerings (See **Figure 21.A**). Since the start of the COVID-19 Public Health Emergency, Nebraska Total Care has experienced more than a 5,100% increase in telehealth claims. Nationally, we have seen positive outcomes. For example, our Washington affiliate's Behavioral Health (BH) telehealth offering significantly increased access to care, with 40% of their members using telehealth reporting that without it, they would not have sought care. As part of a larger survey (that included California, Iowa, Missouri, and New York Medicaid affiliates) of members who had a telehealth visit using the Babylon 360 Virtual PCP program, which we will make available to Nebraska Medicaid members, 9% of members surveyed indicated they would have gone to the ED if telehealth visits were not available. We include more details on Babylon 360 and other telehealth innovations we are bringing to Nebraska later in this response.

Figure 21.A. Multifaceted Approach to Telehealth Delivery

Health Equity Through Telehealth. Expanded telehealth options help close the health disparity gap for Nebraska Total Care members in rural and frontier locations. Telehealth can overcome barriers such as transportation, medical vulnerabilities, work schedules, childcare, and many other daily challenges that interfere with consistent, meaningful health care access, availability, and attendance. Through our Technology Enablement Fund, Nebraska Total Care will provide equipment and support, including computers, tablets, or mobile devices, to further assist telehealth infrastructure and adoption with strategic community health partners and support health equity in needed areas of the State. Through our ConnectionsPlus® program, we also provide free cell phones and data plans to members engaged in Care Management who do not have safe, reliable access to telephonic and web-based services. ConnectionsPlus gives members consistent access to physicians, (health plan) Care Managers, telehealth services, and 911. Nebraska Total Care's Telehealth Specialist and Provider Network team will guide and support providers who have questions or are experiencing challenges related to telehealth services.

Incorporating Member Preference for In-person or Telehealth Services

Giving members a choice in how they experience health care fosters an increased investment in their health and commitment to health-related goals. ***We do not require any service to be provided strictly through virtual means.*** If a member prefers in-person visits, we will accommodate them and honor their preference. By offering platforms that support both direct-to-consumer and traditional facility telehealth-based options, members choose if and how they receive telehealth care.

Providers Using Telehealth

As of 2021, Nebraska Total Care has more than 3,800 contracted Nebraska Medicaid providers using telehealth services. More than 2,350 are behavioral health providers and more than 1,470 are physical health providers.

Operationalizing Telehealth Throughout the State

Nebraska Total Care is making telehealth available statewide. This is especially significant for Nebraskans living in rural and frontier areas, who often lack access to specialists and may benefit from telehealth and specialty eConsults with Primary Care Providers (PCPs). We adhere to all requirements in Scope of Work Section E.7 and reimburse virtual member visits at the same rates as in-person

services, ensuring no cost differentials for members, regardless of how they choose to receive care.

As an integral part of our strategy to operationalize telehealth throughout the State, we are investing in ***innovative telehealth solutions*** that provide members with access to telehealth virtual visits, enhancing member engagement. This improves the quality of care, increases digital health literacy, and promotes health equity by ensuring access regardless of location. We selected specific solutions based on our experience with telehealth in the State and the experience of Centene health plan affiliates in other markets.

Telehealth Innovations

We will expand equitable access to care across the state through solutions including:

- 24/7 virtual urgent care (Babylon)
- Virtual PCP program (Babylon 360)
- Virtual Community Mental Health Center (Brave Health)
- Specialty eConsults (ConferMED)

Virtual Visits for Urgent Care and BH. All Nebraska Total Care members will have access to ***Babylon Health's telehealth platform***, which utilizes leading-edge digital technology and artificial intelligence symptom-checking tools to triage members and determine the correct point of care. Through Babylon, members can initiate two-way video and/or audio 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.

Virtual PCP Program. We are piloting the ***Babylon 360 Virtual PCP program (Babylon 360)***, an innovative program to address member Social Determinants of Health (SDOH) barriers and health disparities, increase access, and advance health equity. Through this model of care, we will 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 will co-manage the member's care by providing Care Coordination, member education on available benefits, community resources, and Care Management programs.

Virtual Community Mental Health Center. We offer ***Brave Health***, a virtual Community Mental Health Center (CMHC) platform providing child, adolescent, and adult psychiatry, therapy, substance use disorder care, hospital transition support, medication adherence intervention, and health navigation services. Health navigation services are conducted through Brave Health's Psychiatric Navigation Program (PNP), which links members to a Navigator who conducts check-ins and provides solution-focused brief therapy to ensure successful linkage with a psychiatric evaluation.

Increase in BH Telehealth

In 2021, 78% of all telehealth visits by members enrolled with Nebraska Total Care were BH-related. From 2020 to 2021, our BH Providers increased telehealth utilization by 8.3% at the Provider Group level and by 11.4% at the individual practice level.

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, compared to only 65% for children without PNP. Brave Health provides a value-based care model that focuses on 7- and 30- day follow-up visits after an inpatient admission to support HEDIS measure improvements and reduce inpatient readmissions.

Specialty Physician eConsult Solution. To support integrated care delivery, we offer ***ConferMED***, a specialty physician eConsult solution enabling asynchronous, store-and-forward consults between PCPs and specialists. This expands specialty care access, decreases service wait times, and reduces avoidable specialist visits, tests, and procedures. ***80% of eConsults result in a recommendation that prevents needing a specialty care visit, supporting members in getting the care they need at the right time.*** This option promotes the ability to share documentation and coordinate care for members.

BH on Board. The BH on Board 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 telehealth crisis services to reduce ED and inpatient admission and unnecessary involvement with law enforcement due to a BH crisis. Tablets include a link to our Findhelp community resource platform. First responders can connect members to community organization who can address immediate SDOH needs.

Remote Monitoring Solution to Minimize Spread of Infectious Disease. Through the ***Kinsa® Health*** program, Nebraska Total Care collects data via a smart thermometer and mobile application to remotely monitor infectious disease spread in communities. The mobile app provides two-way communication to identify and support controlling infectious disease spread through early identification and nurse assistance to support treatment and symptom management. In tandem with this solution, we will analyze and develop corresponding action plans, such as deploying smart thermometers to targeted FQHC and Tribal populations and supporting hyper-local early infectious disease risk detection, prevention, and

preparedness.

Virtual Support for Moms. The ***Pacify and Virtual Doula Program*** offers expectant mothers 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.***

Teledentistry. To meet members where they are, the teledentistry strategy expands access to dental care for members with limited access or difficulty traveling to a dentist or dental specialist. We will 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 will 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. 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.

Telehealth Access Expansion Grants. With the support of strategic community health partners, we offer grants to providers to assist with telehealth adoption to support health equity in areas of the State where access needs can be supported by telehealth equipment and infrastructure building. ***In 2021, Nebraska Total Care and Centene issued a grant to Heartland Health Center (FQHC) through this telehealth grant program.*** They used a majority of the grant to buy home medical monitoring equipment for several members with higher-risk medical needs to support self-management through health monitoring at home. They purchased tablets to support telehealth visits for members and providers, reducing the need to see members in the office during the Public Health Emergency to reduce the spread of COVID-19.

Solution for Social Isolation. We will offer ***Friendly Voices***, an innovative, volunteer-based program to address social isolation and loneliness. Our Care Managers will reach out to members we identify as at-risk for social isolation or loneliness and prioritize them for the Friendly Voices program. The program links local community-based volunteers that engage in ongoing calls or web conferencing with members who desire and would benefit from more social contact.

Linking Telehealth to Utilization Management Strategies

Nebraska Total Care leverages claims and authorization utilization data with qualitative feedback from members and providers via our Provider Advisory and Member Advisory Committees and quarterly town halls, to inform our telehealth strategies. We use this data and input to expand access to physical, dental, and BH telehealth services, giving all members equitable access to health care. We use data-driven analyses to identify areas with health disparities and educate providers and community partners on virtual access opportunities. Nebraska Total Care uses monthly member claims reporting to analyze and identify members who have not had a PCP visit in the last 12 months. Our Care Management staff outreaches to these members to support a referral to Babylon 360 for engagement with virtual primary care, as appropriate.

We review telehealth utilization to address gaps in access. When we identify an access gap, we connect directly with key providers in the area to discuss opportunities for telehealth utilization. We collaborate with our telehealth vendor partners to support providers' engagement with members in underserved areas to alleviate health disparities. In circumstances where we identify potential telehealth overutilization, our Provider Relations and Clinical teams provide education on appropriate use or may refer a provider to SIU for further review for FWA. We track telehealth under and overutilization to identify opportunities to educate members and providers on appropriate service utilization, and maximize positive member outcomes, access, and care gap closure cost-effectively.

22. Describe the Bidder's experience with an integrated pharmacy benefit in other states and specify the type of plan and enrollment. ***Page Limit: 3***

Nebraska Total Care's Experience with an Integrated Pharmacy Benefit

For the past five years, Nebraska Total Care has successfully managed an integrated pharmacy benefit that currently provides more than 120,000 Medicaid members with cost-effective access to therapeutic drugs, including over-the-counter medications. Our years of experience in Nebraska affords insights and knowledge into Nebraska providers and members' prescribing and utilization patterns. This local knowledge informs our day-to-day approach to the pharmacy program to ensure a safe, effective dispensing and utilization environment that drives health outcomes and cost savings. In addition to our local experience, we have experience with integrated pharmacy benefits for Medicaid plans in 24 states:

State	Types of Plans	Enrollment
Nebraska	***TANF, CHIP, Foster Care, SSI Dual, SSI Non-Dual, LTC Dual, LTC Non-Dual, Expansion***	***120,000***
Arizona	TANF, Expansion, SSI Dual, SSI Non-Dual, SPMI/SED, Non-SPMI/SED	473,000
Arkansas	I/DD, BH	15,000
Florida	TANF, LTC, Foster Care, SSI, D-SNP (Medicaid Only), Medicaid Special Needs Children, Children with Special Health Care Needs	1,819,000
Georgia	TANF, CHIP	1,002,000
Hawaii	ABD, CHIP, TANF, Expansion	44,900
Illinois	LTC Non-Dual, SSI Kids, LTC Dual, SSI, Expansion, TANF, BH (IMD), MMP, Foster Care	925,000
Indiana	TANF, CHIP, ABD, Expansion	347,000
Iowa	TANF, CHIP, LTC Dual, LTC Non-Dual, SSI Dual, SSI Non-Dual, Expansion	327,800
Kentucky	SSI Dual, SSI Non-Dual, TANF, Expansion	481,900
Louisiana	Foster Care, BH, SSI, Expansion, TANF	539,000
Michigan	TANF, SSI Duals, SSI, Expansion, Children's Special Health Care Services, MMP	566,900
Mississippi	TANF, SSI, Foster Care	170,300
Missouri	TANF, CHIP, Foster Care	319,600
Nevada	TANF, Expansion, Check-Up	83,500
New Hampshire	TANF, Foster Care, SSI Dual, SSI Non-Dual, Expansion	86,000
New Jersey	ABD/SSI, LTSS, TANF, Expansion	102,200
New Mexico	TANF, Expansion, SSI Non-Dual, SSI Dual, LTC Dual, LTC Non-Dual	85,800
New York	Health and Recovery Plans (HARP), SSI, TANF, Expansion, CHIP, LTC	2,100,000
North Carolina	TANF, ABD Non-Dual, LTSS	575,700
Ohio	TANF, Expansion, ABD Adult, ABD Child, MMP Opt-In, MMP Opt-Out	463,000
Pennsylvania	LTSS Non-Dual, LTSS Dual, SSI Dual	89,000
South Carolina	TANF, ABD, MMP	237,000
Texas	CHIP, TANF, ABD, Foster Care, MMP	1,267,500
Washington	TANF, ABD, CHIP, Expansion, BH, Foster Care	223,300

As an original Heritage Health Managed Care Organization, we have a sense of stewardship over the pharmacy program. Accordingly, we have invested in technology and introduced innovations to ensure the pharmacy program keeps pace with the growth and needs of Heritage Health members and providers.

Pharmacy Benefit Program Accountability and Oversight

Nebraska Total Care will use a pharmacy management model to enable our team to perform critical functions and processes in-house while providing integrated support and oversight of the services performed by our new pharmacy benefits manager, CVS Caremark, including adherence to the Nebraska Medicaid Preferred Drug List (PDL). ***We will not outsource essential administrative and clinical functions*** such as coverage determinations, clinical authorizations, formulary development and management, pharmacy and therapeutics support, clinical pharmacy programs, pharmacy auditing, member and provider call center services, and other administrative and operational functions. CVS will perform PBM functions such as pharmacy network contracting/management, point of sale claims processing, and rebate collection. This hybrid model will promote administrative efficiency by providing our local pharmacy team with control and management of coverage determinations, redeterminations, formulary management, Pharmacy & Therapeutics (P&T) Committee responsibilities, quality measures, Drug Utilization Review (DUR), and member and provider outreach.

Oversight of PBM Operations. We perform scheduled and ad hoc audits of the PBM to ensure compliance with all state, Federal, and contract requirements governing drug rebates, PDL changes, formulary requirements, reporting requirements, dispensing, and monitoring requirements, and e-prescribing. Oversight functions also include, but are not limited to,

ensuring pass-through pricing, monitoring PBM data and performance, and requiring CVS to conduct regular audits of the pharmacy network. We report audit findings to the Vendor Oversight Committee. Additionally, we have controls to ensure dispensing fees and pharmacy prices paid to pharmacy providers are accurate and in compliance with contract requirements, including pharmacy payments made to Tribal Health providers. These controls are periodically assessed to ensure they are designed and operating effectively.

Experience and Performance in Key Pharmacy Areas

Table 22.A Nebraska Total Care Pharmacy KPIs illustrates our capability and readiness to continue serving Heritage Health members, providers, and MLTC throughout a new contract period.

Table 22.A Nebraska Total Care Pharmacy KPIs

Area	Description	Key Performance Indicator(s)
Pharmacy Operations	We continually reinvest in technology that keeps pace with rising claims and (PA) volumes due to Heritage Health's growth, reduces providers' administrative burden, and delivers consistent proficiency in critical operational areas.	• 1.4 million claims processed in 2021 • 100% of claims adjudicated and paid within seven days, exceeding the 90% contract requirement • An average TAT of 3.17 days to adjudicate and pay claims • 98% of the time, we complete PA requests received via phone and fax within 24 hours • The average TAT to process PA requests is 7.52 hours from receipt
Drug Utilization Management	We promote appropriate drug utilization and cost-effective, quality care through a disciplined approach to drug utilization, vigilant monitoring of prescribing practices, and effective educational interventions.	• $3.6 million in cost savings in 2021 • 45% of prescribers who received a recommendation to reduce therapeutic duplication took action to change drug regimens to keep members safe
Psychotropic Medication Use in Children	Our Behavioral Health Medication Monitoring program provides rigorous oversight of psychotropic drugs used to ensure clinically indicated psychotropic medication treatment.	• 46% reduction of medications six months post-intervention • 23% decrease in average per member per month spend post medication intervention • 40% of members obtained recommended lab work for metabolic monitoring within six months of the intervention
Managing Opioid Use	In commitment to helping MLTC meet its opioid dosage taper strategy objectives, we launched a multi-year, multi-prong member/provider education campaign to ***safely taper members down to a 90 MME without compromising specific needs for pain management*****.**	• 48% decline in opioid prescriptions per thousand members since 2017 • $2.1 million in combined savings in 2019 and 2020 in opioid spend
Increasing Access to Medications	Our Pharmacy and Therapeutics (P&T) Committee exercises local decision-making discretion to lift PAs so we can deliver on our commitment to increasing access to therapeutic drugs.	• We listened to our BH providers and lifted the PA for Vivitrol, a substance use disorder drug that helps lower relapse rates and readmissions due to medication non-adherence.
Network Development and Management	Our network of 715 pharmacies provides convenient access for members. This includes a clinically integrated network of 61 independent pharmacies providing members with enhanced pharmacy services, including refill reconciliation, free delivery in adherence packaging, monthly medication review by pharmacists, and outreach to prescribers to close gaps in care.	• The closest pharmacy is only 4.8 miles on average for members living in Rural, Urban Frontier areas. • The closest pharmacy is only 13.9 miles on average for members living in frontier areas

Area	Description	Key Performance Indicator(s)
Payment Innovation	We reimburse pharmacists for expanded medication management services and provide bonus payments for meeting adherence-related HEDIS measures.	• CPESN-NESP pharmacies are eligible for up to $126,000 in combined annual HEDIS bonus incentives for members that meet HEDIS performance metrics. • $60,000 in payments have been made to pharmacists since June 2021 for close to 200 members enrolled in the CPESN-NESP program
Provider Satisfaction	We remove administrative burden, support independent pharmacies, and take a collegial approach to prescriber interventions.	• Nebraska Total Care not only topped all other Heritage Health MCOs' but also posted the highest scores since the Heritage Health program launched in 2017 in the most recent provider satisfaction survey
Pharmacy Program Integrity	Our experienced FWA investigators identify and curtail unnecessary, duplicative, or fraudulent pharmacy activities.	• $574,403 in pharmacy savings generated by the FWA team in 2021

Proposed Innovations Based on our Local Experience

We will use our experience and insights in managing an integrated pharmacy benefit to enhance the pharmacy program and provide new solutions for members and providers. Our proposed innovations for the new contract period, subject to MLTC approval, include the following:

- **Supermarket Pharmacy 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
  - 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
- **Narcan Education Program.** Every two days, someone in Nebraska dies from a drug overdose[20]. 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 customized R-DUR reports. As needed, we will follow up with members to encourage Narcan utilization.
- **CVS Health Tag Point of Sale Campaign.** In collaboration with CVS, this member education campaign uses CVS Health Tags at the point of sale. Health Tags are customized to members' conditions, such as prompting members with diabetes to complete their A1C testing and attached to the members' prescription medications.
- **Prescribing Scorecard.** This tool, provided quarterly, offers prescribers a line of sight into prescribing patterns measured against peers and industry standards to enable them to self-correct, improve their prescribing practices, and deliver appropriate medical care.

[20] "Prescription Painkillers. After the Pain, They're Just Killers." Dose of Reality - Prevent Prescription Painkiller Abuse in Nebraska, https://doseofreality.nebraska.gov/.

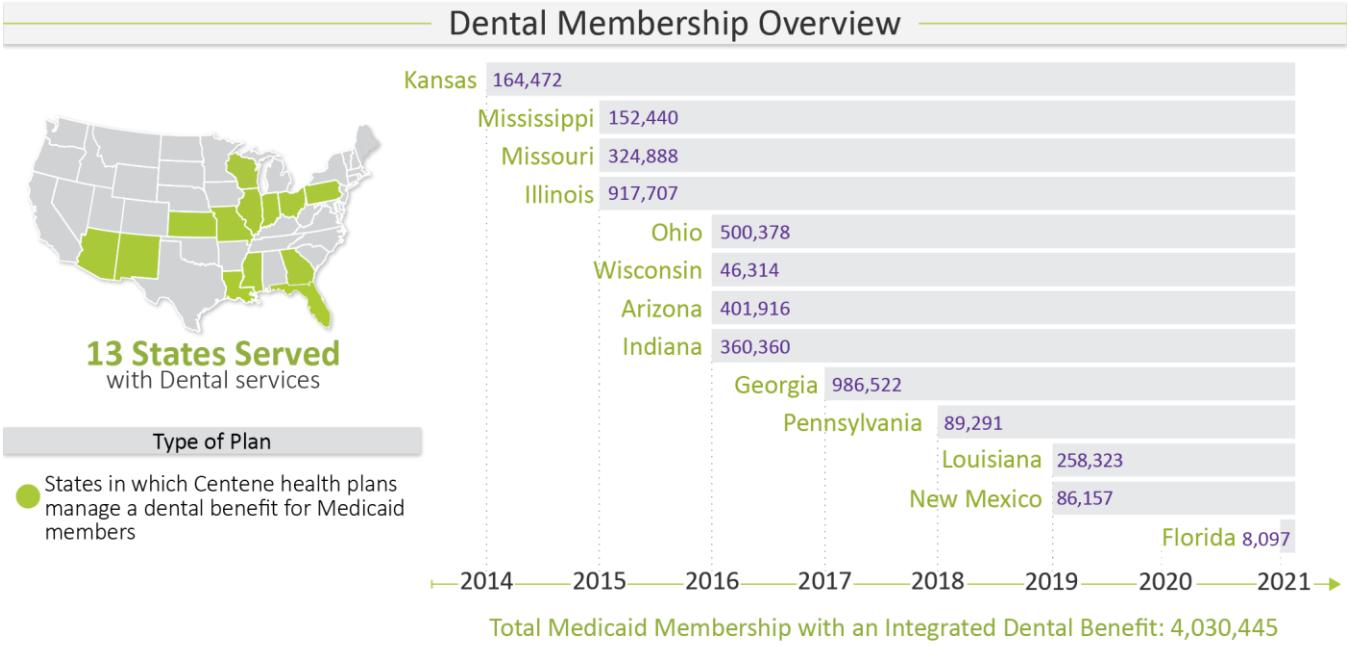
23. Describe the Bidder's experience with an integrated dental benefit in other states and specify the type of plan and enrollment. ***Page Limit: 3***

Dental health is a core component of Nebraska Total Care's integrated approach to benefits, services, and Care Coordination and Management. Our dental strategy is integrated into our overall Population Health Management framework and includes a multi-pronged approach involving member and provider outreach, engagement, and partnership.

Experience with an Integrated Dental Benefit in Other States

As illustrated in **Figure 23.A**, Centene health plans currently manages integrated dental benefits for more than 4 million members in Medicaid-managed care plans across 13 states. Nebraska Total Care will leverage the national experience of our affiliate health plans to offer an integrated dental benefit in Nebraska. Our affiliate health plans conduct an annual dental provider survey in these states. ***In 2021, dental providers participating in the survey submitted responses averaging a rating of 4 out of 5 related to overall satisfaction with our dental plans***. Notable topics that scored well include utilization management, call center professionalism, satisfaction with the number of specialists available, availability of clinical staff, and authorization process accuracy.

Figure 23.A Affiliate Dental Benefit Management Experience



Integrated Dental Benefits Management Strategy for Nebraska

Nebraska Total Care will partner with our dental affiliate, ***Envolve Dental, Inc. (Envolve)***, to administer covered dental services and ensure timely and appropriate access for members. Envolve Dental manages our Nebraska Medicare HIDE SNP benefit in all counties we currently serve. Our new ***Dental Director*** and recently hired ***Dental Management Coordinator,*** Dr. Jon Rich, will oversee this relationship and our overall dental health strategy. Our dental health approach includes programs, systems, and processes to ensure members have timely access to needed services. Core elements of our program include:

- **Educating and training members, providers, and staff** on the availability of, and how to access, covered services
- **Connecting members with primary care dentists for preventive care** and assisting members with developing a relationship with their provider to ensure dental care is administered in the most appropriate setting
- **Including the dental provider as part of the member's care team** (which includes the member's Care Manager, PCP, and specialists) to foster collaboration, communication, and integration of services
- **Reaching out and engaging members and families and working with school-based health centers** to expand our reach and offer member incentives to promote appropriate care and services. For example, we will identify dental providers

Engaging Stakeholders

Since 2020, we have worked with MLTC's dental MCO, MCNA, to coordinate care, identify opportunities to support access for Medicaid members, promote dental health as part of overall whole-person health, and identify Care Management opportunities to support equitable health access in Nebraska.

in the area, provide information on sealant programs, assist with the development of a referral system at the school, and provide information on mobile dentistry partners that can come to the school to perform dental health services

- **Evaluating member needs** through a dental health assessment that identifies service needs and risks
- **Building and maintaining a comprehensive provider network** that is experienced in serving the Medicaid population, culturally responsive and reflective of the population to be served, and well-equipped to serve members with special health care needs
- **Leveraging our Quality Improvement program** to oversee the effective, efficient implementation and management of the dental benefits package (including network adequacy, timely access, and appropriate utilization), such as timely preventive care as measured through HEDIS results
- **Leveraging our URAC accredited, evidence-based Utilization Management program** complying with the Scope of Work
- **Utilizing our information technology system** configured to administer the dental benefit and incorporate dental care gaps, while integrating utilization and assessments into our data-driven decision-making

Integrated, Whole-Person Health. To ensure the successful execution of our dental health strategy and benefits administration, we are partnering with Envolve and our primary care and dental providers to ensure dental health is fully integrated into members' care and services. For example, if a member is overdue for a dental visit, this information will be flagged in our secure Provider and Member Portals. An alert will notify any authorized provider checking eligibility for a member, or any Nebraska Total Care staff accessing the member record. For members in Care Management, we will assess their dental health and access to dental services and incorporate needed services and interventions in the member's plan of care. We will work with Envolve and our dental providers on specific campaigns and initiatives focused on increasing access to dental services. We will access dental data through CyncHealth to inform member dental health preventive care outreach and integrated care planning. We will make information on dental health gaps available to providers and members through our secure Provider and Member Portal.

Engaging Dentists in the Community. Nebraska Total Care and Envolve value our providers and recognize their impact on members' overall health and well-being. Centene affiliates' experience working with dental providers in other markets has taught us that offering electronic claims processing, providing access to our Network and Provider Relations Specialists, and fulfilling our commitments, directly impact rapport building and engagement. Our innovative solutions, educational programs, and provider support result in a comprehensive dental care system that reduces the administrative burden for providers and offers quality dental services to members. We will have:

- Two Provider Relations Representatives assigned to Nebraska
- Provider webinars and in-person meetings to discuss updated policies and clinical guidelines
- Both a provider-facing website and secure Provider Portal with up-to-date materials to provide ease in filing claims and caring for members

Dental Network Readiness

In addition to our Nebraska Medicare dental provider network which currently includes 431 individual dentists and 331 dental groups in 49 counties, we have already secured 34 signed letters of agreement and 24 verbal agreements from dental groups to participate in our network upon award.

Our Provider Relations team will engage newly on-boarded dental providers quarterly through provider webinar training. All contracted and non-contracted providers will have the opportunity to participate in quarterly training to stay updated on new and revised policies, processes, and requirements. We will provide proactive and follow-up training for individual providers, as necessary.

Leveraging Experience to Bring Best Practices and Innovations to Nebraska. Nebraska Total Care will bring the following best practices and innovations to Nebraska. 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.

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

Improving Access to Dental Care

health plan has had success with this approach, providing mobile dental services to 70 schools in 24 counties.

Teledentistry Advice Line. To provide members with more health care service options, we will offer access to virtual dental services. Members who call the Nurse Advice Line and meet clinically appropriate criteria may be transferred to dentists for a telehealth appointment. Members will have access to licensed dentists 24/7/365 to seek care advice for dental-related issues. Dentists providing telehealth services can refer members for in-office care with in-network dentists, as appropriate.

Mobile Dental Vans. For members living in rural, frontier and urban communities, Nebraska Total Care and Envolve 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 summer 2022, we are traveling with Flossy to select counties to offer and apply fluoride varnish to Nebraskans to support health equity and access to regular preventive dental care.*** In August, Flossy will be at the Families First Back-to-School and Project Connect events in North Platte. We will also partner with mobile anesthesia providers to bring dental anesthesia to the dental office setting, to support members living in both rural, frontier 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.

Reminders for Needed Dental Services. We empower children 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 ER for oral pain or dental-related symptoms. A Care Manager or Community Health Worker (CHW) follows 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.

Practice Dental Visits. Nebraska Total Care and Envolve work with our dental providers and community partners to offer dental "practice visits" for members with special health care needs. Our experience has shown that dentists know how to engage members and make them feel comfortable at the dentist's office. By alleviating member anxiety and stress around dental visits, practice visits prompt members to seek the dental care they may not otherwise receive. This approach has proven successful among our Medicaid health plan affiliates in Kansas and New Mexico, allowing members to become familiar with the provider's office, equipment, and processes before the date of service. It also enables the provider to identify barriers, ensuring clear communication before the appointment takes place.

Community Dental Health Expansion Program. ***Nebraska Total Care partners with the Nebraska Association of Local Health Directors to support their Community Oral Health Expansion program.*** This program maximizes the use of 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.

Dental Home. With every welcome call, we talk to members about their dental benefits and the assignment of a primary dental home. We help members schedule an appointment and transportation for needed dental services. Preventive dental services and a strong dental home relationship are two of the most effective ways to reduce inappropriate ER or urgent care use. In addition, when a Member Services Representative or Care Management staff access a member's record, they work to identify gaps in care. This enables these staff members to provide education to the member, real-time, while talking with them on the telephone, and assist them with scheduling appointments with their dental home, removing barriers such as transportation. Nebraska Total Care provides members and providers information on identified gaps in care related to preventive dental services through our secure Member and Provider Portals.

24. Describe how the Bidder will ensure compliance with the Mental Health Parity and Addiction Equity Act, including how the Bidder will evaluate and measure its compliance. ***Page Limit: 3***

Compliance with the Mental Health Parity and Addiction Equity Act

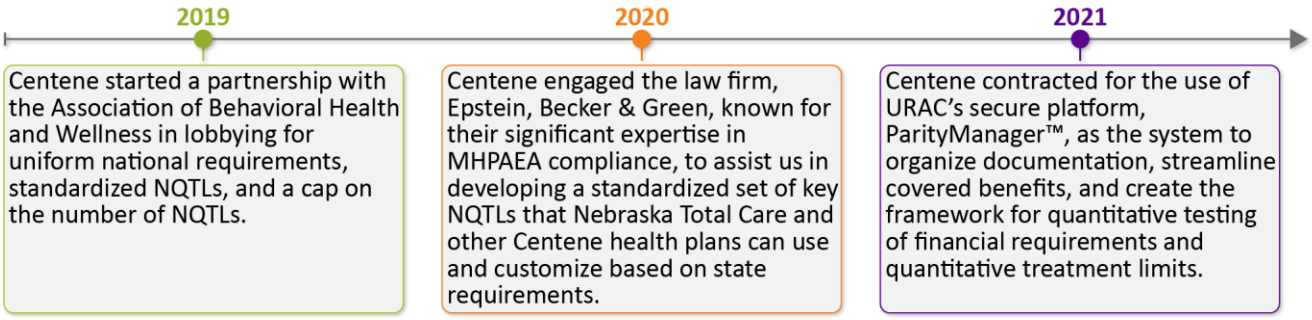
Nebraska Total Care complies with the Mental Health Parity and Addiction Equity Act (MHPAEA), as it applies to Medicaid Managed Care Organizations per section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs); and Children's Health Insurance Programs (CHIP). We ensure that any benefit limitations for mental health or substance use disorder (MH/SUD) are comparable and no more restrictive than those for medical/surgical benefits. We do not impose less favorable limitations on MH/SUD benefits compared to medical/surgical benefits. This includes annual and lifetime quantitative limits, dollar limits, financial requirements, or treatment limits (collectively "Limits").

Nebraska Total Care provides comprehensive, whole health solutions. We have a comprehensive ***Enterprise Parity Compliance Program*** to ensure we comply with the MHPAEA. Our investments and developments in staffing, training, reporting and analysis enhance procedures and uphold Federal parity regulations and laws. All Nebraska Total Care staff and provider training are consistent with the requirements of MHPAEA. We educate staff and providers on the significance of non-quantitative limits (NQTLs) and the importance of compliant utilization management (UM), authorization, and access policies and practices. We require staff and network providers to complete training on topics such as UM criteria and MHPAEA as part of initial onboarding, at least annually, and upon any change in program or requirement.

Nebraska Total Care has a Nebraska-based ***Parity Officer*** to monitor for continual compliance with State and Federal MH and addiction parity requirements and support required actions around the MHPAEA. Our Contract Compliance Officer serves as our Parity Officer and brings to that role a diverse background with nearly 20 years of experience in health care, Medicaid Managed Care, and regulatory compliance. The Parity Officer consults on and helps direct audits, examinations, reporting, and filings related to parity; oversees and monitors plan-level parity compliance; and completes regulatory reviews, disseminates updates, and helps direct implementations necessary because of regulatory guidance. Our Parity Officer and organizational structure allow us to benefit from collaboration with affiliate health plans across Centene Corporation and leverage best practices related to parity review, compliance, and monitoring.

Improving Our Enterprise Parity Compliance Program. To strengthen our Enterprise Parity Compliance program, our parent company, Centene, made several investments, including those listed in **Figure 24.A**.

Figure 24.A. Proactive investments to improve Centene's Enterprise Parity Compliance program underscore Centene's and Nebraska Total Care's commitment to MH parity in all Centene health plans.



Administration of Benefits to Ensure Compliance with MHPAEA

Nebraska Total Care provides services that are focused on resiliency and recovery. With parity values in the forefront that support service accessibility, we continue to offer members access to the full continuum of care available, always working with the member and provider to ensure services are delivered in the least restrictive setting while continuing to respect and evaluate the member's safety needs and anticipated health outcomes.

We uphold continued compliance with the Paul Wellstone and Pete Domenici MHPAEA of 2008 (45 CFR Parts 146 and 147). Nebraska Total Care administers benefits for MH/SUD as designated and approved by the State-specific contract and plan benefits (for example, Value Added Services). We ensure equality in terms of QTLs and NQTLs with that of services delivered to treat physical health (PH) conditions. We evaluate and measure compliance to MHPAEA through a multifaceted approach, including policy review and adherence to benefit authorization requirements, authorization processes, and applicable limits.

We make medical necessity determinations for MH/SUD benefits available to all members in the same manner as PH benefits. We utilize evidentiary processes to review clinical criteria for MH/SUD services in the same way we do for medical

and surgical benefits. These types of benefits are in the same classification when determining the extent of a benefit that is subject to NQTLs. With this in mind, we apply all parity standards to out-of-network coverage for MH/SUD benefits to ensure we are no more restrictive related to behavioral health (BH) OON services than we are for medical and surgical benefits.

To ensure transparency in determinations, Nebraska Total Care providers and current/potential members may request UM reviewers' service authorization documentation to review medical necessity determination elements. We provide the reason for denial of reimbursement or payment concerning MH/SUD benefits to members 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.

Proven Parity Compliance

Nebraska Total Care conducted an extensive parity compliance review in partnership with MLTC that yielded no parity concerns requiring correction. We review our parity policies annually to ensure ongoing compliance.

Application of Medical Necessity Criteria in Compliance with MHPAEA

Evidence-Based Criteria. Nebraska Total Care adheres to NCQA Health Plan Accreditation requirements for UM and complies with Federal and State requirements for medical necessity determinations, and all related Scope of Service requirements. In accordance with MHPAEA, we ensure that medically necessary covered services, and those additional benefits implemented by Nebraska Total Care, are not arbitrarily or inappropriately denied as well as reduced in amount, duration, or scope. This begins with adopting and/or developing evidence-based clinical support criteria. First and foremost, our UM process is grounded and informed by MLTC's service definitions and Nebraska Administrative Code regulations.

For both medical and BH services, Nebraska Total Care uses the current written/electronic version of the InterQual Connect™ Level of Care and Care Planning Criteria. For substance use services, we use the American Society of Addiction Medicine (ASAM). For therapies and rehabilitation, we use Nebraska Total Care's Medical Management Guidelines; and Federal and/or State of Nebraska statute and/or regulatory guidelines. We use available Comparative Effectiveness Research (CER) data when developing our clinical policy for specific procedures. Our CER sources include Hayes Clinical Research (an internationally recognized research and consulting firm that evaluates medical technologies to determine the impact on member safety, health outcomes, resource utilization, and return on investment); UpToDate® (an evidence-based, physician-authored clinical decision support resource); National Comprehensive Cancer Network guidelines; Agency for Healthcare Research and Quality searches; and Centers for Medicare and Medicaid Services guidance.

Relevant Guidelines and Consistent Application. To ensure relevance for the enrolled population, Nebraska Total Care's Clinical Advisory Committee (CAC) obtains input on proposed clinical policy statements, medical necessity criteria, and clinical practice guidelines from local practicing physicians and providers familiar with the specific needs of members in the Heritage Health program. The CAC and the UM Committee (UMC) approve our clinical criteria and medical necessity guidelines. Upon approval, Nebraska Total Care distributes clinical guidelines to UM staff, including Medical Directors, who attend mandatory training before they use the criteria in medical necessity appropriateness reviews.

We train, monitor, and provide regular feedback to staff, and conduct monthly inter-rater reliability audits. We ensure all staff understands how to apply criteria and document medical necessity decisions into TruCare Cloud, our collaborative care and UM platform. These proven techniques facilitate consistent criteria application, routine oversight, and process effectiveness evaluation. Nebraska Total Care staff review our Parity policies at least annually and ensure ongoing compliance with the requirements of those policies.

Evaluation and Measurement of Compliance with MHPAEA

Nebraska Total Care evaluates and measures compliance with MHPAEA through a review of MHPAEA policy adherence, in addition, to benefit authorization requirements, authorization processes, and applicable limits. Nebraska Total Care monitors a variety of channels to ensure compliance and detect issues early. Examples of monitoring include grievances and appeals, member and provider satisfaction, and utilization reports. We regularly review key areas of our operations, financial strategies, and clinical protocols to ensure compliance. ***Nebraska Total Care has developed an MHPAEA work plan that includes the completion of the Self-Compliance Tool for the MHPAEA by July 1, 2023.***

Clinical Considerations. We regularly monitor our specific processes, strategies, and best practice standards utilized to determine how benefits are allotted. Specifically, we validate that the processes we use to determine how and when to apply limitations for example, prior authorizations, are the same for BH and PH-related events. Our UMC reviews processes for compliance with MHPAEA annually, or more frequently when benefits or guidelines change. The CAC reviews recommendations from the UMC to facilitate network provider and stakeholder participation in the process, thus providing additional layers of oversight. The CAC forwards recommendations to the Quality Assessment and Performance Improvement Committee (QAPIC) for final review and approval.

Operational Considerations. The importance of validating the operational functions of Network Management, Compliance, UM, and Care Management is fundamental for ensuring access to the full benefit continuum for Nebraska's Medicaid members. Nebraska Total Care validates that we effectively manage and appropriately staff our operational and administrative structures to meet the obligations of MHPAEA. We train staff annually and implement oversight protocols on MHPAEA and principles of parity to ensure understanding and compliance.

Financial Considerations. Nebraska Total Care is cognizant of the financial requirements and treatment limitation considerations for MH and SUD benefits. We compare and review our policies and procedures to ensure parity to determine QTLs or NQTLs for BH and medical/surgical services. We use a thorough review and analysis process to determine where, when, and how to apply potentially limiting techniques, including UM for outpatient services, precertification for services, and concurrent review.

Nebraska Total Care works with the other MCOs, providers, and stakeholders in Nebraska via ***administrative simplification meetings*** to streamline and create consistency for key BH service authorization requests. These efforts led to the adoption of common forms by all MCOs to request community-based Medicaid Rehab Option services like Day Rehab, Community Support, and Assertive Community Treatment (ACT) services. Through our work in the current MCO association, of which our CEO is the President, we actively seek collaborations and opportunities to make working with MCOs less burdensome.

Parity Reports. Nebraska Total Care will submit a Mental Health and Substance Use Disorder Parity report, in alignment and at the cadence necessary, to meet MLTC requirements. Through this report, we will detail the design and application of managed care practices such as PA, reimbursement rate setting, and network design.

RFP 112209 O3

B. Technical Approach

V.F Member Services and Education

V.F Member Services and Education

25. Describe member services processes including:
• Training of customer service staff (both initial and ongoing).
• Routing calls to appropriate persons, including escalation.
• Making information available to customer service staff (the type of information and how it is provided, e.g. hard copy or online search capacity).
• Handling calls from members with limited English proficiency and persons who are hearing impaired.
• Monitoring and ensuring the quality and accuracy of information provided to members.
• Monitoring and ensuring adherence to performance standards.
• How MSRs will interact with other organizations including MLTC, other MCOs, and other programs/social service entities (e.g., WIC, housing assistance, and homeless shelters).
• After hours procedures.
Page Limit: 6

Member Services Processes Focused on Member Experience

Nebraska Total Care maintains and staffs a locally responsive Member Services Call Center that serves our members, their families/caregivers, and providers. Our toll-free telephone line is available during business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, Central time. Member Service Representatives (MSRs) are equipped with call center tools and technology to ensure prompt service and accurate information. We maintain a 24-hour Nurse Advice Line that is staffed with qualified nurses to triage urgent care and emergency calls from members and to facilitate the transfer of calls to a Care Manager from or on behalf of a member who requires immediate assistance. Members calling during non-business hours can leave a message with their Care Manager, and the call is returned the next business day. We ensure that the Member Services Call Center is adequately staffed with well-trained MSRs to answer all calls in a manner that meets or exceeds contract requirements. MSRs are supported by supervisors for real-time assistance with needed information to meet the member's needs.

No caller ever receives a busy signal when calling Nebraska Total Care. Every call is answered, and every caller may speak with a courteous and knowledgeable representative no matter when they call. For convenience, our interactive voice recognition telephony system (IVR) responds to voice and push-button prompts and includes self-service features, such as ID card replacement.

Our Automated Call Distribution system (ACD), complements our Concierge Service model and meets or exceeds contract requirements for managing, measuring, assessing, and recording calls during business and non-business hours, including weekends and holidays. To speed service to the member, our Computer Telephone Integration (CTI) platform automatically populates the member's record (call history, demographics, care gaps, etc.) on the MSR desktop screen, based on the member's ID number and date of birth.

> "The representative that helped me today really did a great job. Knowledgeable about her job and knowing how to get me the info I need. I appreciate it. Love calls like that. Wasn't stressful or hard at all. Her name was Shantell. Great job and thank you guys for your services."
>
> *- Nebraska Total Care member*

As explained throughout the response below, we develop Member Services Call Center policies and procedures that address staffing, training, hours of operations, access and resource standards, transfers/referrals, including Case Management referrals, monitoring of calls via recording or other means, and compliance with contract standards.

Member Services Staff Training

Nebraska Total Care ensures that the Member Services Call Center is adequately staffed with individuals trained to accurately respond to member questions regarding managed care, including covered services, the Medicaid program, EPSDT, and our provider network. We know that the best member engagement is through staff that represent Nebraska's diverse cultures and populations. Nebraska Total Care recruits former/current Medicaid recipients via resources such as NEworks, Ticket to Work, and community career fairs. We train MSRs to deliver outstanding member service. We prepare them for every scenario, from the rare emergency call to the more typical request such as assistance with provider appointments. We monitor and coach their performance with full-time Supervisors, Trainers, and Quality Specialists dedicated to the call center.

We teach our MSRs to provide ***anticipatory service specific to the member needs,*** employing a host of member engagement tools. MSRs are trained to administer the SDOH Mini screening, recognize members presenting SDOH needs, and provide an immediate referral to the case management team, who will provide specific recommendations and information to community resources. The same MSR who answers a member's call ensures resolution of any member issue, provides all follow-ups and refers the member to any needed community support. This minimizes hold time and repetition, offering no wrong door for any inquiry.

Week Zero. MSR training begins with our innovative ***Week Zero training*** during which newly hired MSRs review our website and member materials such as the Member Handbook, orient to our systems, shadow calls, and get to know our organization. Engaging and peer teaching activities support adult learning methodology and a more thorough understanding of content during training. A solid grounding in our organization and culture provides a much more meaningful foundation to begin training.

Week Zero

Our innovative Week Zero training has decreased the amount of time Member Services Representatives take to demonstrate full job readiness as indicated by productivity and quality assurance evaluations ***from 180 days to just 65 days***.

Initial Training. To ensure MSRs are knowledgeable and skilled before taking member calls, our Member Service Trainer (Trainer) provides ***an initial three-week comprehensive training program*** using Adult Learning Principles through classroom instruction, role-playing, hands-on demonstrations, interactive online modules, and quizzes to ensure comprehension. Departmental experts from Compliance, Pharmacy, Behavioral Health, Dental, and Care Management, among others, inform the coursework and communicate each department's role in our integrated, member-centric approach that supports each member.

- ***Fundamentals -*** covers member service and telephone etiquette; use of all desktop systems and documentation; Medicaid 101, including managed care; covered services; provider network; all internal departments and programs, for example, Quality, Pharmacy, Dental, Tribal Liaison, and Provider Relations; claims and prior authorizations; member materials; emergency management protocols; confidentiality and HIPAA; and fraud, waste, and abuse.
- ***Programs -*** covers accessing services; overview of MLTC, its policies, and contract; an in-depth review of populations and Covered Services, including limitations; exclusions and co-payments, where applicable; the member-centric, integrated System of Care approach used in our Care Management team; Value Added Services; role and importance of the medical home; EPSDT schedules; all Federal and Nebraska regulations on marketing, including 42 CFR 428.10; our website, member and Provider Portals, Caregiver Resource Center, and mobile applications.
- ***Job Functions -*** covers the day-to-day responsibilities such as how to: verify caller authorization, especially for children in Foster Care; locate providers and set appointments; provide services via a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U); deliver care gap and wellness alerts; understand prior authorization process, claims look-up; transportation and provider accessibility standards; deploy protocols for immediate warm transfer to our 24/7 nurse advice line; manage Care Management referrals and access Physical and Behavioral Health (BH) Care Managers for immediate assistance; appropriate identification and handling of quality of care/service concerns; provide web and mobile application navigation assistance; access language interpreters, use Nebraska Relay, and deliver alternative format materials.

Culturally-Responsive Training. Nebraska is an ethnically, culturally, religiously, and geographically diverse State with active immigration and refugee resettlement and more than 30 spoken languages. We hire MSRs that represent this diversity. We train our MSRs to approach member interactions with the requisite base of knowledge and cultural competence to direct them to the most appropriate resources.

At the time of hire and semi-annually, MSRs complete our Cultural Competency Training Program, reflected in **Table 25.A.**, based on the 15 enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). We train in elements of culturally sensitive care for specific Nebraska populations, such as Latino/Hispanic, Native American, Vietnamese, and Arabic members. This training equips our MSRs often help eliminate barriers and identify community resources and supports using our community resource guide and screening tool.

Table 25.A Cultural Competency Training

Topic	Description
Cultural Sensitivity 101	Addresses the impacts of cultural differences in health care across at-risk populations, as well as educates about the laws and tools available to ensure culturally sensitive care. The training is designed to increase understanding of cultural factors, including race, ethnicity, language, sexual orientation, gender, age, disability, class, education, and religion.
Unconscious Bias	Provides education on how to recognize individual biases and evaluate strategies to challenge relative biases in the workplace.
Health Equity Learning Circles	Examines the root causes of health inequities through health disparity education and dialogue sessions. Participants explore beliefs around health inequities and establish a common ground for action. Learning Circles culminate in the implementation and evaluation of a targeted health disparity project.
Health Literacy	Provides strategies for considering literacy when working with individuals, including assessing needs and preferences, the importance of using plain language to support understanding, and opportunities for staff to learn how to provide basic information to encourage making appropriate health decisions.
Panel Discussions	Focuses on how each of us can play a role in making health equity a reality for Members and the communities we serve.
Person-Centered Thinking	Uses core concepts developed by Michael Smull and the Learning Community for Person-Centered Practices to train participants on how to support Members in making informed decisions, developing personally defined outcomes, and setting their own goals.

Monitoring and Testing. After newly hired MSRs successfully pass written and oral comprehension checks, they spend at least one week in observed side-by-side calls, and up to another 30 days of job shadowing with daily monitoring before taking member calls independently.

Ongoing Training. Weekly, MSRs meet with Supervisors to review call trends and new information, such as upcoming member educational events. Bimonthly, the Trainer refreshes understanding, such as how to encourage pregnant members to have a prenatal visit within seven days after notification of pregnancy or enrollment. Quarterly, the Trainer deploys a mandatory MSR training tailored to specialty areas such as pharmacy issues, dental, and supporting members with special needs. Ongoing, we support Nebraska-focused training through a "train the trainer" model bringing our MSRs instruction from local representatives of offices such as the Office of Health Disparities and Health Equities or League of Human Dignity. Whenever possible, we include local/State social service support organizations in our quarterly mandatory MSR training. For information requiring immediate action, such as changes in benefits or related issues affecting members, we employ QMindShare, an important element of our electronic learning system that delivers high-impact communications and requires the MSR to respond to content with a quick quiz for comprehension.

Routing and Escalating Calls

Upon receipt of the call, our IVR system greets callers and offers push-button and voice-activated prompts in English and Spanish. The IVR advises callers to immediately hang up and dial 911 if the call is an emergency. Our new IVR system will allow callers to say "agent" for an MSR; "nurse" for nurse advice; or "behavioral health" for specialized BH assistance or urgencies. Calls normally do not route among call center staff because all MSRs have the same training, technology, and resources. Our MSRs increase satisfaction and first call resolution by providing anticipatory service, such as offering whatever the member needs (for example, scheduling assistance, medication refill dates, prior authorization, claims status) and notifying members about alerts in their file (for example, a care gap or when their Care Manager needs to speak with them). When a call transfer is necessary, we provide a warm transfer during which the MSR introduces the member to the appropriate staff person to ensure continuity and eliminate repetition for the caller. If a warm transfer is not possible the member is given direction on the next steps.

Non-Urgent Clinical Issues. We train MSRs to identify and immediately warm-transfer to our 24/7 nurse advice line (NAL) for non-urgent or emergent issues (how to care for a feverish child, etc.). For calls requiring Care Management, a warm transfer is made to this team; if not possible, we ensure a Care Manager is notified and returns the member's call within 30

minutes during business hours and has the necessary information to resolve the member's issue. The Care Management team receives a daily activity report from NAL staff that includes information on any necessary member follow-up.

Crisis and Urgent Clinical Calls. We train at initial hire and provide ongoing training to help MSRs identify situations indicating an emergency, such as seizure, poisoning, or a pregnancy-related emergency. In an emergency, an MSR alerts a supervisor for assistance using an all-day open communication channel, ***Open Chat,*** and places a three-way call to 911, remaining on the line with the member for safety. If the member lives in an area not serviced by 911, the Supervisor connects with other emergency options (local fire or police departments, or hospital-affiliated ambulance services).

For urgent needs, the MSR, using a best practice protocol, alerts a Supervisor, starts a three-way call with one of our Nebraska licensed physical or BH Care Management clinicians (depending upon need), and stays on the line for safety until released by the clinician. If the member's electronic record indicates the member is in Care Management, the MSR warm transfers to the designated Care Manager to ensure that the member receives consistent, appropriate responses tailored to their medical history. If a warm transfer cannot be made, the Care Manager will return the member's call within 30 minutes with access to the necessary information to resolve the member's issue.

Pharmacy Calls. We train MSRs to handle routine pharmacy inquiries (benefits, PDL explanation, etc.). If more expert attention is required, such as for members in Foster Care who leave needed medications behind during placement changes, MSRs use our ***Route and Resolve Process.*** Using a formulated template, MSRs provide our Pharmacy staff with details, and the Pharmacy staff work on the issue as a priority, reaching out to the local pharmacist or prescriber as necessary. Within 30 minutes or less, the Pharmacy staff report back to the MSR with the resolution, and the MSR contacts the member with the results. This relieves the member of the burden of multiple contacts or wasted time.

Ensuring 'Sharon' Has Needed Medications. Sharon contacted a Nebraska Total Care Member Services Representative (MSR) very concerned about her inability to fill her heart medication. Our MSR swiftly intervened and coordinated with our Pharmacy Services team to arrange for Sharon to immediately pick up her heart medication from her pharmacy. Our MSR also contacted Sharon's provider to answer questions and provide additional guidance to ensure Sharon can obtain future prescriptions without delay. Sharon expressed her appreciation for our MSR's quick and thorough actions, noting, "I wish all employees could be like that."

Making Information Available to Member Services Staff

MSRs have all necessary information readily accessible through our ***Customer Relationship Management Platform (CRM),*** which integrates, manages, and provides access to accurate, up-to-date member data (based on Role-Based Access Controls). This includes ***member eligibility and service history information***, including care gaps and wellness alerts, call history, claims history, and authorizations. Additionally, MSRs can access resources to support members, including:

- ***Pharmacy management database***, including claims history, authorization status, last fill date, pharmacy name and demographics, and Preferred Drug List
- All ***provider demographics***, for example, hours of operation, panel status, and languages are spoken, in our searchable database with GPS mapping, to provide directions to callers as needed
- All ***educational and administrative member and provider materials*** and community events schedules
- Our website and social media, member portal, ***community resource screening tool for SDOH***, Caregiver Resource Center, mobile applications; co-browsing capabilities to assist members with screen navigation
- ***Policies and procedures***, workflows, scripts, training guides, important internal and external contact names, and phone numbers, for example, NEMT and Enrollment Broker.

Handling Calls from Members with Limited English proficiency and Persons Who Are Hearing Impaired

Callers with Limited English Proficiency (LEP). Our IVR greets callers in English and Spanish, and offers all self-service options, including an ID card request, in both languages and routes the call to appropriate English/Spanish bilingual staff. For other languages, or if no Spanish-speaking MSR is available, the MSR immediately accesses our language services with professionals providing culturally appropriate oral translation for more than 200 languages, including Vietnamese, Arabic, and Somali, meeting all CMS, HIPAA, and ACA regulatory requirements.

Bilingual Staff

To facilitate communication in members' preferred language, we employ three Spanish-speaking staff.

MSRs note all language and communication needs in our CRM Platform for future calls and the integrated CTI notifies the MSR of members' language needs as the call arrives at the workstation, speeding service. MSRs also arrange for in-person interpretation for members' provider appointments available at no cost to the member. We inform members that oral

interpretation is available for all languages and that written material is available in both English and Spanish on our website, in all written materials, and during interactions.

Callers who are hearing impaired. We ensure MSRs are equipped to take calls from members with disabilities, including those with hearing and speech disabilities. For a member with hearing impairment, we display the Nebraska Relay TTY/TDD number prominently in our Member Handbook, member educational materials, and on our website, and train staff in the use of, and proper etiquette for, these services. MSRs arrange for in-person American Sign Language interpretation for the member's health care appointments through resources such as the Nebraska Commission for the Deaf and Hard of Hearing (NCDHH) Statewide interpreter referral service.

Callers with Any Communication Issue. Our ACD uses a best practice "stay on the line" feature which automatically connects a caller to an MSR if the caller does not press phone keys or respond orally to menu options. For convenience, a caller also may say "agent" at any time and be connected to an MSR.

Addressing 'Cliff's' Concerns and Ensuring Equitable Access to Care. Cliff, who is blind, recently called his Care Manager (CM) very upset, stating the security team at his provider's office had acted very suspicious of him and asked him to provide them with 24 hours' notice for future appointments. Cliff told his CM he was worried he would not remember to do this and felt he was being banned from his provider's office. Cliff's CM validated Cliff's feelings and contacted the provider's office to discuss Cliff's concerns. The CM discovered that Cliff had been spending long periods in the lobby while waiting for specialized transportation to take him home from his appointments. Cliff's CM worked closely with the provider office to ensure the security team was aware of Cliff's needs and reasons for spending time in the lobby. The CM then followed up with Cliff, who felt relieved he would be able to continue seeing his provider without the security team's interference.

Monitoring and Ensuring the Quality and Accuracy of Information Provided to Members

To ensure exceptional, anticipatory service, we monitor the quality and accuracy of MSR responses and phone etiquette through our customized ***Call Quality Assurance (CQA) Program***. Our full-time ***Quality Specialists*** (Specialists) audit a higher number of calls for newly hired MSRs than tenured MSRs with excellent previous audit scores. We record phone interactions for quality review and simultaneous use of desktop resources. Our Specialists assess courtesy, accuracy, effectiveness (such as delivering appropriate care gap information), cultural appropriateness, and call documentation on each MSR's audit report card. Any score on an individual call that falls below 90% triggers review and retraining.

Quality audit results are provided to Supervisors and MSRs immediately. Supervisors review the quality results with each MSR monthly. We maintain recorded calls for 14 months and incorporate "live" call examples into training. Supervisors assure inter-rater reliability with a monthly quality call calibration session using random calls. MSRs participate in a quality rebuttal program, reviewing and scoring sample calls as a training exercise to ensure accuracy and fairness.

Performance Monitoring Leads to Live Chat Feature

Through performance monitoring, we identified the need to improve call quality for pharmacy-related member calls. To enhance the member experience, we established a live chat feature that enabled collaboration between the pharmacy and MSR to facilitate real-time resolution of the member's concern.

As an enhancement to our system, we will use a state-of-the-art post-call survey for our members. Within the IVR menu, callers will be offered the option to participate in a brief post-call survey. Upon completion of the call, the member will receive an automated callback and answer a brief survey indicating their level of satisfaction with Nebraska Total Care and the MSR that handled the call. This direct member feedback is critical to inform and improve the quality of our Member Service staff.

Adherence to Performance Standards.

We monitor all Member Services call center performance measures against MLTC standards in real-time and report data monthly, quarterly, and annually through our quality management structure. This information is shared with MSRs and other staff and, if performance is below the established threshold, a plan of action is developed, implemented, and tracked for effectiveness. We meet and exceed contractual requirements and will continue to meet or exceed MLTC's member call center performance standards. **Table 25.B** includes data for 2019, 2020, 2021, and 2022 through April.

Table 25.B Member Call Center Performance for Nebraska Total Care with MLTC Standards.

Year	Call Volume	Average Speed to Answer	Abandon Rate	% of Calls answered within 30 secs.	Average During Call Hold Time	% Busy Signal
MLTC Target	**NA**	**30 sec.**	**No more than 5%**	**90%**	**3 min. or less**	**No more than 1%**
2019	44,185	15 sec.	1.5%	91.3%	70.5 sec.	0%
2020	42,638	16 sec.	2.5%	91.7 %	68.5 sec.	0%
2021	54,412	10 sec.	1.5%	94.2 %	75.5 sec.	0%
2022 (as of April 2022)	19,334	18 sec	2.6%	90.02 %	77.5 sec.	0%

Working with External Entities

To help address the social determinants of health, for example, access to food, housing, job training, and social support which impact our members' wellness, our MSRs direct members to our online referral database, powered by ***Findhelp*** (resource database) with access to all community and governmental resources. For routine referral and requests, such as to MLTC, help with Find-a-Provider/Provider contact or the Division of Children and Family Services, MSRs provide all needed information (hours of operation, etc.) and warm transfer members to the service. For community-based resources, such as when a member reports food insecurity or requires WIC, MSRs refer members to our resource database of community supports, such as advocacy groups, local food banks, community clothes closets, and housing supports.

For more specific, personal needs, we deploy our ***SDOH Mini-Screening***, a dynamic service to identify, refer, and follow up with members in need of social or behavioral services. With Case Management assistance, members take a baseline questionnaire that dynamically populates different questions based on the member's answers and offers referrals specific to that member. When needs are identified, MSRs warm-transfer a member to Case Management and to our Community Health Workers (CHWs) who provide personal, in-field assistance.

After-Hours Call Procedures

After hours, our IVR call routing system offers the same automated services and prompts, including advice about 911, as described above. Members may use voice or push prompts for PCP assignment, ID card replacement, and other self-service features, and may leave a voicemail message, which is returned by staff within one business day. Callers also may receive nurse advice or medical assistance by saying "nurse" or prompting the IVR for our 24/7 NAL. Qualified nurses answer questions, provide advice and triage, and have immediate access to our Care Management team and Medical Director through an after-hours on-call assignment roster. ***Our Care Management team receives a daily activity report from NAL staff,*** including inquiries requiring follow-up no later than the next business day. At any time, members can access important personal health and wellness information and administrative functions on our website, our secure member portal, and via our mobile applications.

Figure 25.A Nebraska Total Care's member engagement model meets members where they are.

26. Describe the approach the Bidder will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the Bidder will ensure that materials are at the appropriate reading level. ***Page Limit: 2***

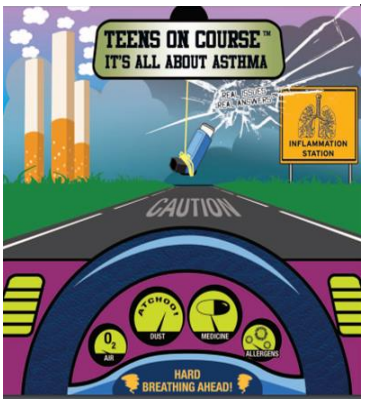
Member Materials: Delivering the Right Message in the Most Engaging Style

Nebraska Total Care provides all members with easily understood written material and distributes written member materials to new members within 10 calendar days of enrollment. We inform and revise our content with input from providers, members, our Member Advisory Committee, Tribal Healthcare Committee, Health Equity and Diversity Committee (HEDC), and other valued stakeholders, to develop publications that motivate each member toward self-management and improved health and wellness. For example, members have access to, My Route to Health, a comprehensive library of easy-to-understand books that provide information on steps they can take to stay healthy. Books are customized for adults, children, and adolescents (see **Figure 26.A**).

We use every opportunity to deliver health literacy messaging for on-the-ground distribution, such as through our Community Health Workers (CHWs), Care Management teams, and Health Coaches; and via mobile-friendly web files, videos, webinars, texts, and emails. For members with language, alternative communications, or developmental needs, we offer alternative formats, materials accurately translated into other languages, over-the-phone real-time interpretation, and reading/explaining English text to members. Our website is fully compliant with section 508 of the Rehabilitation Act, with quarterly internal and annual External Quality Review (EQR) audits to ensure continuous accessibility.

We understand and comply with Federal, State, and contractual regulations regarding member materials and member education. All materials are reviewed by Nebraska Total Care subject matter experts, Marketing and Communications, Quality, and Compliance before submission to the State for approval. Legal approval is included when appropriate.

Figure 26.A Nebraska Total Care Promotes Health Literacy



Member Materials are Easily Understood

Members of our Marketing and Communications Department complete the Institute for Health Care Advancement's Health Literacy Certification Program, which includes areas of focus such as Communication, Community Engagement, Public Health, and Language, Culture, and Diversity. These trained professionals work in collaboration with subject matter experts across all departments to create member materials and community engagement activities. We evaluate all materials for ease of use related to creative design, including layout, graphics, images, and color. Nebraska Total Care also ensures materials maintain a consistent language, branding, and design to ensure recognizability and brand confidence. We obtain member feedback from local member and stakeholder focus groups for these materials to determine their efficacy, appeal, and readability, developing best practices for our materials.

Providing Alternative Formats. We provide member administrative and educational materials in alternative formats, including large print, braille, and digital links to materials compatible with screen readers. All materials, including the Member Handbook, are tested using screening tools and screen readers to ensure audio accessibility using free accessibility tools. Our website includes links to a recognized screen reader. Member educational videos include closed captioning for visual and audio accessibility and include topics such as asthma and diabetes self-care, mental health, medication management, and health literacy. Our website is 508-compliant and does not require anything beyond a reasonably up-to-date browser to access information and tools.

Members can obtain immediate, personal assistance from our Member Services Call Center and Nurse Advice Line staff, who will read, explain, or provide translation assistance for member materials, or arrange for alternative formats. For members with low literacy skills, visual limitations, and /or limited English reading proficiency, we train all member-facing staff to read and explain materials in a sensitive and culturally appropriate manner. For members with hearing difficulties, we employ Nebraska Relay in English and Spanish, and train staff in the effective, appropriate, courteous delivery of services, such as speaking directly to the member and not the Relay Operator. Our member publications and website display the Nebraska Relay number prominently.

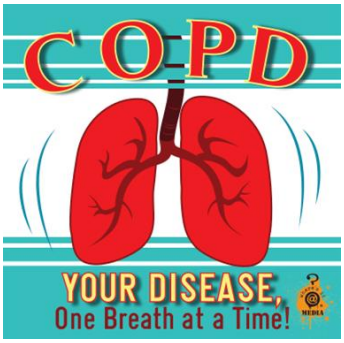
In-Person Interpretation Assistance

As a value-add, Nebraska Total Care offers in-person language and American Sign Language medical interpreters for covered services appointments.

We offer our Member Handbook, website, and other materials in both English and Spanish and will print materials in any language upon request by the member. We use certified professional translators for all material translations and maintain certificates of accuracy. Member Service Representatives (MSRs) provide members with a real-time interpretation of materials in any language through our national interpretation partner with medical expertise and meeting CMS, HIPAA, ACA, and other regulatory requirements.

Making alternative and non-English materials easily accessible. We inform members of the availability of alternative formats and materials in other languages, and how to access them on our website, Member Handbook, correspondence, and during all member touchpoints, such as via Care Management and Member Services. Our Member Handbook, website, and all critical plan materials advise members in the top fifteen most frequently spoken non-English languages to call our 24/7 toll-free telephone number to request information in other languages.

Figure 26.B We provide members with the right materials in simple formats.



Identifying and delivering the right materials to the right members. All member-facing staff inquire about member material needs and immediately send requested material to members either by mail or email based on the member's preference. We use demographic information, health, and claims history, and member interactions to identify care gaps and aftercare needs to guide and inform information sent to members. For example, a member with an asthma diagnosis is sent information on treating and managing asthma. Through our Member Care Compass we ***deliver the right message in the right format at the right time for maximum impact and member engagement.***

To ensure the right member receives requested materials, we use technology tools to check, standardize, and update addresses. Member addresses are validated through two processes:

- Coding Accuracy Support System – our address list is compared to a national database of all known addresses and is standardized and cleansed.
- National Change of Address (NCOA)– a process whereby address files are compared to the NCOA database which is maintained by the USPS. This process updates an address if the member has filed a 'change of address record' with the USPS. The address is updated to the new address the member provided to the post office. NCOA is recommended because it reduces the number of undeliverable (and returned) mail pieces. NCOA is also required by the post office to qualify for postage discounts with certain classes of mail.

During member interactions, MSRs and all member-facing staff confirm member address and contact information, facilitating ongoing outreach and engagement.

Appropriate Reading Levels

Promoting Health Literacy

We write our member materials at a 6th grade reading level and use plain language, pictures, and icons for ease of understanding.

We write our member materials at a 6th-grade reading level and test them for readability using the Flesch-Kincaid Readability Test. ***When developing member materials, we write the way a person talks; we use a friendly tone, active voice, common words, and short sentences; and provide examples.*** We adhere to People First Language and the National Institutes of Health Easy-To-Read Guidelines for health materials. To ensure maximum impact, we incorporate feedback on our member materials from our Member Advisory Committee, Tribal Healthcare Committee, network providers, and community stakeholders. Compliance reviews member materials for all Federal, State, and contract requirements before submission to the Division of Medicaid and Long Term Care (MLTC) for final approval before production.

Material Accessibility

To promote the accessibility of our member materials, we present information in formats that meet their needs. To ensure accessibility for all Members, our public website, secure Member Portal, and MyNTC Member Mobile App use standard templates compatible with Section 508 of the Americans with Disabilities Act (ADA) accessibility standards. All of our 508 Compliant member materials, including the Member Handbook, Member Newsletters, Provider Directory, and Preferred Drug List (PDL) are available for print and are mailed to members upon request. Our centralized Accessibility Program Office (APO) ensures compliance with all Accessibility Standards, including Section 508. The APO engages with our staff from requirements discovery through design, development, testing, and implementation. The APO ensures 508 compliance at each step using automated tools integrated through our accessibility scanning suite.

27. Discuss the Bidder's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the Bidder would use to effectively welcome members. ***Page Limit: 3***

New Member Welcome Approach

Nebraska Total Care's comprehensive new member activities, supported by our Data, Member Services, and Care Management teams, meet and exceed MLTC's communication requirements. ***We tailor our communication strategies and materials to promote member engagement and active participation in their health and wellness beginning on Day 1 of enrollment.*** In the first 75 days of membership, we provide members with a comprehensive understanding of plan benefits and services, how to access care, the role of preventive care, and how to contact Nebraska Total Care for assistance.

Figure 27.A Nebraska Total Care's Onboarding Journey

Day	Channel	Communication Topics
1	—	834 file received and integrated into data systems
1	Email	Welcome. Watch for member packet and ID card. Upcoming phone call from nurse. NebraskaTotal-care.com. Online New Member Welcome Center
1	Text	Welcome. Watch for member ID card. Member Services. Online New Member Welcome Center (hyperlink)
3	Email	Choose PCP. Take the Health Risk Screening. Rewards program
10	Text	Received member ID card? If not, request from Member Services. Member portal (hyperlink)
10	Mail	Welcome packet delivered.
11	Email	Using ID card. Schedule annual health visit. Checkup with PCP. Member portal
By Day 15	Phone	First Welcome Call attempt
15	Text	Visit PCP within 30 days (hyperlink). Rewards programs
Approx. Day 20	Phone	Second Welcome Call attempt if needed.
22	Text	Health Risk Screening. Member Portal (hyperlink)
Approx. Day 25	Phone	Third Welcome Call attempt if needed.
25	Email	Online tools: NebraskaTotalcare.com, member portal, Find a Provider search, Krames Health Library, myStrength, findhelp.org, Member News/Events, MyNTC mobile app
29	Text	Rewards program (hyperlink). Complete yearly exams and screenings
36	Text	Free smartphone app (hyperlink)
39	Email	Benefits list, Member handbook, benefits webpage, value-added services
43	Text	Benefits overview. Value-Added services (hyperlink)
50	Text	Care Management (hyperlink). Nurses, social workers, behavioral counselors & community health workers
53	Email	Care Management, Community Health Services, Notice of Pregnancy form, pregnancy resources page
57	Text	Emergency care. 24/7 Nurse Advice Line. Where to go for care (hyperlink)
64	Text	Rights and responsibilities (hyperlink)
67	Email	Where to go for care. 24/7 Nurse Advice Line, PCP visit, Urgent care, Emergency care. Mental illness or addiction crisis line
74	Email	Rights, responsibilities, notice of privacy, contact for Member Services. Thank you for engagement.
75	Text Email Phone	Members enter the ongoing Member Connection education program.

Email Text Phone Mail

Daily Enrollment File. The first step to ensuring timely outreach and welcome materials is the timely and accurate processing of enrollment files. Our enrollment team maintains policies and procedures governing the receipt, processing, and promulgation of 834 membership and supplemental enrollment file data across our MIS and those of our subcontractors. We process HIPAA 834 change transactions for our State Medicaid clients daily. We process inbound files within 24 hours of receipt via our secure file transmission system and integrated EDIFECS middleware, which validates and maps each data item in the 834 to the membership input file format of our MIS. We support daily and weekly membership reconciliation processes, comparing all member records at a given point in time with MLTC to ensure complete and accurate data capture.

Member Data Management. As an integrated component of our Customer Relationship Management (CRM) platform, our Unified Member View (UMV) system supports all informational aspects of each member's relationship with Nebraska Medicaid. This includes member identifiers, address, contact information, confirmed or potential family linkages, special needs, member preferences, for example, communication options such as e-mail, phone, and/or mail, along with a history of any change to each attribute.

UMV uses matching logic and gives us the automated ability to link an inbound member record with historic "eligibility spans", for example, prior history as a Heritage Health member. 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 to make sure we have the most current address for members on record. Using Identity Verification and Authentication data services, we enhance the accuracy and quality of member data. We never overwrite the eligibility information we receive from MLTC's 834 files. Instead, we securely store alternate contact information we receive as a complementary attribute of the member data and notify MLTC of updated information as appropriate.

Welcome Packets. Our new-member Welcome Packet is mailed to all members for receipt within ten business days of our receipt of the new member file. It includes the member ID card and a welcome letter with Member Services contact information. ***Our website information flyer*** assists members with accessing our website and the information provided on it, including the Member Handbook and Provider Directory; secure member portal registration; rights and responsibilities, how to access benefits, and how to contact Member Services for materials in hardcopy if the member does not have web access or needs assistance.

New members receive a 'checklist' of actions that can maximize their health benefits such as completing the included Health Risk Screening and Notification of Pregnancy on paper, by phone, or in the secure member portal. Postage-paid return envelopes are included for all member forms. We resend welcome packets if we discover that the member has lost or never received the information. We submit the contents of the welcome packet to MLTC for review and approval, as required. Nebraska Total Care's materials continue to remain compliant with Scope of Work (SOW) requirements and 42 CFR 438.10 (f)(6).

Additional New Member Education Strategies. To supplement our new member welcome packet, members receive additional information via email and text messaging. Using these strategies, communication begins within 24 hours of receipt of the 834 files, encouraging members to actively engage in their health care. We use multiple modalities for communication to create the best possible opportunity to reach members. Nebraska Total Care ensures that within 90 days of enrollment, members receive needed information to access services and participate in their health care.

We centralize member communications, allowing us to distribute information in a way that increases engagement and minimizes member abrasion. ***Member onboarding emails maintain an open rate of over 40%, double industry standard, demonstrating the effectiveness of this communication method.*** Through emails, we provide education on the importance of the PCP relationship, Health Risk Screening, accessing benefits, and using Care Management and other tools and resources that help members make healthy choices.

> "I am the daughter, representative, & Power of Attorney for 'Flo'. Mom is under the care of the nursing home, and I do not live in Nebraska and travel a lot. I appreciate everything you send me via email. This is the best way to communicate with me."
>
> *- Nebraska Total Care member representative*

Welcome Calls. Our Member Services Call Center conducts new member welcome calls within 10 business days of receiving the eligibility file. This proactive approach helps members access preventive care quickly and identifies immediate medical needs such as pregnancy, complex care needs, or SDOH concerns. As part of the welcome call, highly skilled staff complete the Health Risk Screening, ensure the member knows their PCP, and inform them of the opportunity to change their PCP if that is their preference. We orient members to the importance of having and engaging with their PCP and scheduling preventive care services.

During welcome calls, staff educate members about covered benefits, provide an overview of our program and services, and answer any questions. They ensure members know how to contact us for assistance, including how to access free oral interpretation and written translation services, if needed. We make a minimum of three attempts to call newly enrolled

members. We report to MLTC, monthly, the name, telephone number(s), and Medicaid Recipient ID Number of each member we are unable to contact after three attempts.

PCP Assignment. If an active PCP selection is not included on the enrollment file or made during the welcome call, Nebraska Total Care assigns a PCP before mailing the welcome packet. Members are provided education on how to select and change their PCP in the welcome packet, through onboarding emails, and welcome calls.

Continuity of Care and Care Management Needs. Members with immediate needs (as identified through the Health Risk Screening, a pregnancy flag on the enrollment file, historical claims and/or authorization data provided by MLTC or transitioning MCO, or risk stratification) are referred to our Care Management team for follow-up. Our Care Managers outreach to members with high-risk levels within 24-72 hours of identification and members with moderate-risk levels within five days of identification. They complete a comprehensive assessment of the member's physical, BH, functional, social, and other needs and help address any immediate issues or concerns.

Our Care Managers send the member a text message ahead of calling them to support a successful outreach. A Program Coordinator contacts members with low-risk levels within two weeks of identification to address Care Coordination needs, such as assistance scheduling appointments and transportation and making linkages to community services. If indicated, the Program Coordinator connects the member to a Health Coach to further assess for disease management support or to a Care Manager for a comprehensive assessment.

For new members undergoing treatment, Care Management staff help coordinate care during the 90-day transition period to ensure no delay in treatment. During that first 90 days, we honor all prior authorizations and inform members of their right to continue treatment with any prescribed medications and receive services from non-contracted providers. We proactively solicit member information including open authorizations, two years of claims history, and members in Care Management, from MLTC and/or any transitioning MCO. This information helps us identify immediate needs and prioritize outreach to members with the highest level of need.

Additional Strategies Deployed to Welcome All Members

Recognizing that not all members respond to the same approach, our outreach and education strategies take advantage of every opportunity and health plan interaction to ***meet members where they are.*** Our onboarding education program ensures all members know our operations, available services, and how to access care. Our member engagement efforts continue through a member's health care journey. For example, we flag members who have been unreachable in our Customer Service Management (CRM), so when the member does contact the Nebraska Total Care, we can address health care needs during that interaction. We also host and/or participate in community outreach and member education events, leverage our member portal features and mobile apps, and reach out to members in their homes and communities using Nebraska Total Care Community Health Workers (CHWs).

24-Hour Support. Our Member Services Call Center reinforces our welcome materials. Clinical assistance and benefits guidance is available to all members through our 24/7 Nurse Advice Line, with the option to refer members to Care Management for ongoing Care Coordination, as needed.

Local Approach. Recognizing that our community partners are often in meaningful positions to support members, we ensure those organizations have the necessary resources to facilitate engagement with Nebraska Total Care members. Our local approach to engagement involves community liaisons who serve as a direct connection to Nebraska Total Care and bring materials and information to members in their communities.

We bring resources to the most rural and frontier communities and develop solutions and educational strategies that work for each unique community. Our CHWs and Community Outreach staff are located throughout the state to ensure they are knowledgeable about local resources and can relate to members based on the local cultural, geographic, and demographic differences. Nebraska Total Care's presence in the community allows us to solicit feedback about how our programs and services can be improved.

"Thank you for your email. It's very helpful. I don't know where to look for this information I would probably still be searching for it. Good service needs to be recognized because sometimes it's pretty few and far between. Again please thank everyone for providing this information to me."

- Nebraska Total Care member

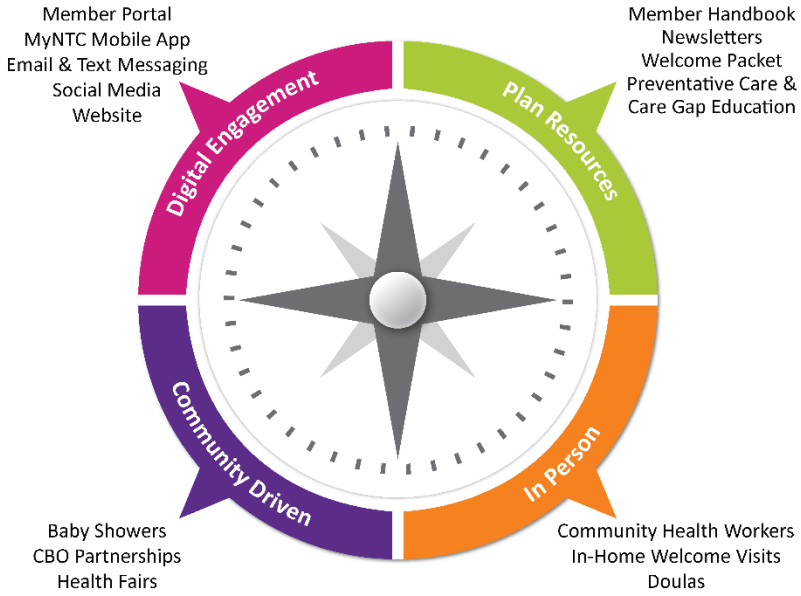
28. Detail the strategies the Bidder will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles. ***Page Limit: 5***

Nebraska Total Care Guides Members to Access Appropriate Care

Nebraska Total Care has developed innovative, timely, and population-appropriate educational and other resources that emphasize the importance of preventive care, improve health literacy, and empower individuals to engage in their health. For example, our Health Equity Dashboard enables us to identify members with a disparity so we can intervene. As described throughout this response, we deploy member and provider-focused strategies to influence member behavior to access health care resources appropriately and adopt healthier lifestyles.

Member-focused strategies. Nebraska Total Care is dedicated to educating members on the importance of a healthy lifestyle with preventive care and its long term benefits on overall wellness. We develop effective, comprehensive health education and outreach programs that assist our members and their caregivers to value preventive care and be accountable for their health and wellness. As outlined in **Figure 28.A**, whether it is in the community, our Member Services Center, a provider visit, our digital outreach, or member portal, we take a proactive approach to member wellness. Our multi-modal communications model aligns people, processes, and technology to holistically support members throughout their health care journey, with real-time information and transparency across all service touchpoints, enabling us to engage members in culturally relevant and meaningful ways, according to their preferences.

Figure 28.A Member Care Compass is our multi-faceted approach to influence member behavior through timely outreach and education.



Health education. Our health education materials are written in plain language at the MLTC prescribed 6th-grade reading level, making it easy for members to understand their benefits package while highlighting the need for preventive care and wellness. Health care information is accessible to all Nebraska Total Care members through our free online Health Library, powered by Krames, which contains evidence-based, peer-reviewed information on over 4,000 health-related topics in multiple languages. Krames uses health literacy principles to increase readability and comprehension and motivate healthy behaviors. Through Krames, members can learn about wellness, illness, plans of care, medications, and other tips and facts.

While educational information is critical to understanding healthy behaviors, Primary Care Providers (PCPs) and trusted community partners also reinforce prevention and wellness. We encourage members to see their PCP at least once annually; from 2020 to 2021, we saw an 8.4% increase in PCP visits. With the integration of dental health services, we will include messaging about dental cleanings and exams in relevant written materials such as our Member Welcome Packet. We develop relationships with trusted partners across the State who work with members on healthy behaviors. For example, we are in discussions with Nebraska's Association of Local Health Directors to place Community Health Workers (CHWs) and Program Coordinators in local health departments to help individuals and communities develop behaviors that prevent or manage diseases and address health disparities.

Strategic Member Programs. Understanding that each member is unique and faces access barriers such as transportation or interpretation needs, we develop strategic programs that encourage members to access health care resources and adopt healthier lifestyles. From perinatal programs to chronic condition management, Nebraska Total Care is equipped to assist each member in their health care journey. **Table 28.A** includes examples of our strategic member programs.

Table 28.A Our strategic member outreach programs promote healthy choices.

Program	Description
ED Diversion Program	• 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. • CHWs located across the State provide in-home visits for members and engage them in the community. CHWs educate members on appropriate ED utilization and alternatives to the ED. • ***This program is highly effective, reducing ED utilization by 27.2% between 2017 and 2021.***
Start Smart for Your Baby®	• Includes enhanced member outreach and incentives, wellness materials, intensive Care Management, provider incentives, and support for the appropriate use of medical resources to extend the gestational period and reduce risks of pregnancy complications and premature delivery. • Care Coordination staff help members select appropriate primary care, dental, women's health, and OB/GYN providers and connect members to postpartum care and Social Determinants of Health (SDOH) resources. • CHWs host baby showers for members who are pregnant or recently delivered. This may include participation from a Care Manager who can provide personalized education, answer members' questions, and connect them to community resources.
Doula On-Demand	• Offers expecting and new mothers 24/7 virtual access to doulas, dieticians, and lactation consultants. • ***Has shown a 26% decrease in non-emergent ED visits and a 23% increase in breastfeeding rates.***
Client Assistance Program (CAP) for Behavioral Health (BH)	• Value Added Service (VAS) allows any member to seek brief, solution-focused therapy services and support their mental health. • CAP sessions can support members experiencing depression, anxiety, or who need help quitting substances like tobacco or alcohol. • Members can visit any Nebraska Total Care Behavioral Health (BH) provider for CAP sessions, in person, or by telehealth to ease access and privacy concerns, which is particularly helpful for rural and frontier communities.
Adolescence to Adulthood (a2A) Program for Transition Age Youth	• Provides specialized, goal-oriented Care Management to transitional-age youth in Foster Care. • Our Foster Care Liaison works with members to discuss risk factors and develop a Healthy Living Plan to assist them in successfully transitioning to independence. • **Our affiliate's a2A program** ***increased referrals, including 41% connected to housing or independent living programs, 58% connected to employment assistance, and 48% connected to GED, trade school, or college assistance.***
Member Care Gap Outreach	• Encourages members with care gaps to receive preventive care appropriate for their age, gender, and health conditions and to participate in annual well-visits with their PCP. • Deploys a monthly outbound call and email series focusing on well-visits for adults and children. For example, we routinely monitor for lead screening and our Care Management team provides proactive outreach calls to the parents of children identified as having this gap in care. • As part of proactive outreach, we assist with scheduling an appointment for the lead screening with their PCP and address any barriers, as appropriate.
Diabetes Management	• For adult members with Type 2 uncontrolled diabetes, particularly in Hispanic and Tribal communities, CHWs provide education on nutrition, exercise, and the disease itself to improve diabetes self-management skills and lifestyle changes. They address SDOH needs at every visit. • The program reduces the member's A1c, decreases the member's weight, and works towards medication adherence and seeing their PCP/specialist. • ***Through these efforts, there was a 37.5% point increase in the rate of members with an A1c result from 2018 to 2021.***
Chronic Condition Management	• Includes evidence-based disease management programs grounded in education and self-management skills training that empowers the member to take charge of their health. • Addresses chronic conditions such as diabetes, asthma, obesity, BH, and heart disease. • Connects members to CHWs who promote a coordinated, proactive, disease-specific approach to improve self-management and clinical outcomes; and control associated costs. • Includes appointment scheduling and transportation assistance to ensure members can get to their appointments.

Program	Description
Fluvention	• Educates and incentivizes members to receive annual flu vaccines. We engage members through automated calls, postcards, flyers, texts, social media, and health fairs.
Tobacco Cessation	• Includes a provider toolkit with information and referral forms for the Nebraska Tobacco Quitline, resources for reducing smoking during pregnancy, information on how to bill for tobacco cessation counseling, and prescription cessation aids covered by Medicaid.
Weight Management	• Includes education and health coaching for the adoption of healthy lifestyles. • As a VAS, offers access to online Weight Watchers to help members increase physical activity, increase healthy food consumption, and increase visits with their PCP. ***In 2021, we provided 139 Weight Watchers memberships.*** • Weight Watchers allows members to create individualized weight loss programs; eat foods they love while integrating healthy foods and increased physical activity; and provides a dedicated coach and encouragement for members to make incremental, sustainable behavior changes.

Community Health Workers (CHWs). Our CHWs are culturally responsive and equipped to address member needs in communities across the State, helping local members address their unique challenges and health disparities. CHWs are a consistent community presence, engaging with members where they are and providing a formalized range of activities that increase member awareness of health conditions, treatment protocols, and the importance of preventive care. Our overall member health education and health literacy approach ***make healthy living easier by meeting with members where they work, live, play, and worship.*** Our CHWs eliminate barriers to health and wellness by conducting face-to-face visits with members and families. They provide intensive education, social support, and informal support in members' homes or locations such as Federally Qualified Health Centers (FQHCs); county health departments; faith communities; community centers; libraries; Women, Infants, and Children (WIC) centers; and other venues.

Community Engagement Team. Our Community Engagement team works in members' communities to understand their unique needs and better serve members where they are. This team builds partnerships at both the community and member levels through education, service integration, and resource development. The Community Engagement team participates in health fairs and other community-based events, providing education about required exams, immunizations, lead screening, preventive services, and local community resources. ***Since 2019, this team has participated in over 190 health fairs and community-based events throughout Nebraska related to children's health alone.***

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.

Health Equity. Access to appropriate health care resources and adopting a healthy lifestyle can be more difficult for members facing health disparities. To identify and better support these members, we use our proprietary Health Equity Dashboard to identify members experiencing health disparities in HEDIS and other quality measures. Additionally, our Neighborhood, Economic, and Social Traits (NEST) tool is a risk model that uses member and public data sources to predict member and community-level risks attributed to social factors. Our Care Management team, staffed with Registered Nurses and Behavioral Health professionals, initiates targeted support for members identified through our Health Equity Dashboard and NEST tool to reduce barriers to care. For example, We partner with the ***Fork Farm*** hydroponic garden system at Hastings Middle School. Sixty percent of Hastings Middle School children receive free or reduced-price lunches, and many parts of Hastings are considered a 'food desert.' Fork Farm allows children to learn about growing food and healthy eating and provides opportunities to eat the food they grow; the Fork Farm machine produces 25 pounds of fresh greens and herbs per month that individuals can then plant in-home or community gardens. Nebraska Total Care aims to offer the community of Hastings over 1,000 vegetable and herb plants to be grown by individuals and their families.

Our approach to supporting members in accessing community resources includes Findhelp, our online social needs resource

database that allows members and their care team to locate and access resources for any SDOH need. This searchable database provides up-to-date information on current community resources, such as housing, transportation, food banks, job opportunities, BH services, and more. Findhelp offers resources in all of Nebraska and border towns like Council Bluffs, Rapid City, Denver, and Sioux City.

My Health Pays® Member Incentives. Nebraska Total Care offers financial rewards via My Health Pays to members actively engaged in healthy behaviors and decision-making based on local trends, MLTC priorities, and past performance. Members can earn rewards by completing healthy activities like annual doctor visits, cancer screenings, flu vaccinations, infant well visits, and notifying us of pregnancy. Nebraska Total Care's My Health Pays incentives are MLTC-approved and OIG Advisory No. 20-08 compliant to motivate members' healthy behaviors and participation in prevention and wellness activities. Our incentives actively promote personal health care responsibility and reward healthy choices and treatment adherence. From February 2020 to February 2022, ***members increased their engagement in preventive services:***

- 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
- 103.7% increase in breast cancer screening
- 110.2% increase in annual PCP visits

Innovative technologies promote healthy behaviors. Nebraska Total Care deploys innovative technology solutions to provide members access to convenient tools and resources that assist with the self-management of chronic conditions.

Telehealth. Nebraska Total Care continues to invest in telehealth solutions that not only provide members with access to virtual visits but also enhance member engagement. We are seamlessly transitioning members to Babylon Health's (Babylon) telehealth platform. Babylon's platform utilizes artificial intelligence symptom-checking tools to triage members and connect them with a provider for a telehealth virtual visit, from which they may be given a diagnosis, treatment plan, and medications as necessary. ***Our Medicaid affiliate's use of Babylon led to a 72% decrease in inappropriate ED utilization for members.*** Babylon also assists members in finding and scheduling an appointment with our network providers and refers members to the next appropriate point of care as needed, for example, in-person PCP or specialist. Members may also use the Babylon mobile app to set medication and symptom tracking reminders, helping them proactively engage in their health.

With the integration of dental health services, we are working with a local university to expand its teledentistry program. This program allows dental providers in rural areas to conduct two-way consultations with dental specialists employed by the university. The program's teledentistry equipment connects to distant sites in communities around the State, including a hospital and community health center.

Digital Health Connect. Nebraska Total Care's 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 Case Managers enabling easy two-way messaging. Each program consists of a targeted curriculum that improves engagement and member self-management. Through the app, we send evidence-based, peer-reviewed care guidelines and literature into a daily mobile to-do list of articles, surveys, encouragements, and reminders. Nebraska Total Care recently implemented Digital Health Connect's maternal care program to provide enhanced support to members throughout their pregnancy based on communication preferences. Through Digital Health Connect's maternal health program, our Medicaid affiliate saw a statistically significant increase in prenatal visit adherence and an overall increase in HEDIS measures for prenatal and postpartum care compared to those not enrolled in Digital Health Connect.

Member Engagement through Digital Health Connect

Digital Health Connect supports high member engagement, with 75% of participating members interacting with the program weekly, and an 80% member satisfaction rate.

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 several "self-service" functions, such as viewing their clinical service and medication history, changing PCPs, updating their contact information, taking an online Health Risk Screening and SDOH Mini-screen, viewing a health or care gap alert, communicating with our staff, and checking the balance of their My Health Pays incentive program. Families with multiple Nebraska Total Care members can view all dependents in one account, making it easy to see rewards or care gaps for each child. Additionally, the Member Portal

provides informational resources and tools members need to understand their health coverage and stay engaged in their health and wellbeing. Members can also access information via the ***Nebraska Total Care Member Mobile Application***, which allows members to view plan benefits, and access their ID card and PCP information among other details.

Nebraska Total Care coordinates with our network of PCPs, FQHCs, and other provider types to share education and tools needed to help members understand the importance of preventive care and healthy lifestyles.

Actionable data. We recognize that information sharing between, and coordination with, multiple entities is to facilitate access to care at the right place and the right time. Nebraska Total Care offers a secure Community Partner Portal for authorized users on the member's care team to bi-directionally share and access key member and provider demographic and clinical information. We invite providers and other partnering agencies to use the Community Connect Portal to stay informed on member activity and needs while maintaining the security and privacy of protected health information. Our partners include State Foster Care Case Workers, Doulas, and CHWs from public health departments. Users can view member eligibility status, care gaps, health record data, for example, immunizations, allergies, labs, other insurance information, and plans of care, and can upload key documentation, member assessments, and free text and structured notes. Equipped with this shared information, the member's care team directs the member to appropriate care settings and services to reduce duplication and improve health outcomes.

Care Gap Closure Program. Our Care Gap Closure program supports PCPs in engaging members with chronic conditions such as diabetes or chronic obstructive pulmonary disorder to close care gaps and get members the appropriate care. We perform risk analysis on member lists to determine predictive and prescriptive groups. Providers review their assigned member list and a checklist of identified gaps through the Provider Portal and work to close those gaps through appropriate health care resources. This program has resulted in a 62% increase in providers actively working to engage members in care gap closures.

Clinical Training. We offer provider education through our comprehensive clinical training program, both in-person and via webinar. Our provider training enhances the knowledge, skills, and performance of health care professionals who empower members to make positive health behavior changes and promote the member-provider relationship. Our trainers have extensive knowledge in a variety of topics, including BH, nursing, exercise physiology, Case and Utilization Management, and Care Coordination. We offer many free courses for CEU's to enhance integrated care and expand the use of best practices, which will include dental topics upon implementation of the new contract. Participants receive BH and nursing continuing education credit for certain classes or certificates of attendance related to certain licensing requirements.

Integrated Care Education. Given the acute shortage of BH providers in Nebraska and the inexperience of some PCPs with BH treatment, Nebraska Total Care is bringing solutions to expand access to integrated BH services. We bridge the gap by engaging and educating PCPs about their role in providing BH services to members and coordinating care for co-existing Physical Health (PH) and BH conditions. By increasing the number of PCPs that offer BH services, crisis events decline. In 2021, we saw a 36% increase in BH-related PCP costs, while BH-related inpatient stays and ED visits decreased by 26% and 2%, respectively. BH-related PCP visit costs for those involved in Foster Care increased by 37%, with declines in inpatient (42%) and ED (48%) costs.

Provider incentives. Through our QualityPATH Value-Based Purchasing (VBP) programs, we incentivize providers for engaging members in appropriate and timely preventive health and disease monitoring services per evidence-based clinical guidelines. Our VBPs address health equity, drive quality, improve member and community health outcomes, and reduce costs. From 2019 to 2021, we achieved significant HEDIS measure improvements within our Primary Care Incentive Pay-for-Performance (P4P) Program:

- 31% increase in childhood immunizations
- 15% increase in children's lead screenings
- 13% increase in controlling high blood pressure

Nebraska Total Care's multi-faceted communications model, health equity and SDOH stratification tools, targeted member outreach, and provider-focused strategies contribute to our successful approach to influencing member behavior to access health care resources appropriately. Our member education and outreach programs emphasize the importance of preventive care, improve health literacy, and empower individuals to adopt healthier lifestyles.

29. Describe the processes the Bidder will put in place to ensure the Bidder does not restrict the choice of providers from whom the member may receive family planning services and supplies. ***Page Limit: 1***

Nebraska Total Care provides full access to family planning providers within our network and from out-of-network (OON) providers without requiring authorization and without any restrictions as specified in 42 CFR 431.51(b)(2). Our claims processing system is configured with edits to prevent inaccurate denial of family planning services and supplies. To further ensure that there is an unrestricted choice for these services and supplies, we review member complaints, appeals, and grievances. We act accordingly to address both individual member issues and any systemic issues.

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.***

Family Planning Policy. Our family planning policy fully aligns with all State and Federal mandates and the RFP scope of services, and includes coverage for an annual physical examination and health history; follow-up visits; laboratory services; prescribing and supplying FDA-approved contraceptive supplies, devices, and methods; contraceptive counseling services; prescribing medication for specific treatment and related follow-up visits, including lower genital tract and genital skin infections/disorders, and urinary tract infections, when diagnosed during a routine family planning visit; and male and female sterilization procedures and treatment of major complications from covered family planning procedures. Services include detection and treatment of sexually transmitted infections and age-appropriate vaccination for the prevention of human papillomavirus infection and cervical cancer. Our policy states that members can access these services through any Nebraska Medicaid enrolled provider, regardless of whether the provider is in or out-of-network with Nebraska Total Care.

System Configuration to Ensure Claims Payment. As part of our policy, we do not restrict the choice of provider from whom the member may receive family planning services and supplies. This policy is built into our claims system configuration rules to systematically pay these services by an appropriate Nebraska Medicaid enrolled provider without authorization, whether in- or out-of-network. Our claims processing system is configured to ensure timely payment of out-of-network family planning providers at no less than 100% of the FFS rate in effect on the date of service for properly billed claims.

Member Education and Staff Training. To ensure adequate choice and promote continuity of care within our network, we educate members on their right to access such services from any Medicaid provider. Our Member Handbook includes information about our family planning coverage, unrestricted provider choice, and member education on reproductive health and contraception. Our family planning policy is built into our utilization management processes and staff training to ensure all members have open access to these services without any delay. In addition, we train all member and provider-facing staff to address family planning and access to services at each appropriate contact. For example, our Member Service Representatives are trained to “continue the conversation” regarding reproductive life planning with postpartum mothers during home visits and follow-up contacts.

Provider Training. Nebraska Total Care provider training addresses our family planning policy and promotes Primary Care Provider (PCP) involvement in reproductive health screening and counseling, especially for adolescent and young adult members. We provide information and training on industry best practices and American College of Obstetricians and Gynecologists' recommendations and trends, such as the use of postpartum Long-Acting Reversible Contraception (LARC).

We publish our family planning policy in the Provider Handbook to ensure all providers understand that members are not restricted by our provider network when choosing to access family planning services and supplies. While member choice is not restricted, we do encourage family planning providers to communicate with the member’s PCP when any form of medical treatment is provided. In alignment with Federal Title X policy, our approach promotes responsible behavior; supports the wellbeing of families and healthy babies; reduces mother and infant death, unintended pregnancies, child abuse, and sexually transmitted diseases; and allows the timing of pregnancies when couples are in the best position to care for new children.

30. Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the Bidder has used for member education.
Describe how the Bidder will provide equitable member education throughout the State. Provide examples and descriptions of how member education will be used to improve service coordination including:
• Integration of physical, behavioral health, and pharmacy services.
• EPSDT compliance.
• Appropriate emergency room utilization.
• The use of prenatal services.
• The use of technological tools, including social media and mobile technology.
• Partnership with community-based organizations for education and outreach.
Page Limit: 10 (Per Addendum 1, Q&A #109 examples are not included in the page limit)

Member Education and Materials Used with Medicaid and CHIP Populations

Nebraska Total Care knows that the most effective way to communicate with members is to offer multiple methods that consider member preferences. We offer direct, high touch, in-person, digital, mail, and telephonic communication that meets members where they are as illustrated in our Member Care Compass, described in response to Question 28. We deploy innovative education methods to improve whole health integration including Physical Health (PH), Behavioral Health (BH), pharmacy services, and dental services; maternal health and EPSDT compliance; preventive care; appropriate emergency department (ED) utilization; and Social Determinants of Health (SDOH).

Member Education Plan. At least 150 calendar days before the contract start date, we will submit an updated Member Education Plan to MLTC for review and approval. We will continue to ensure all member materials are pre-approved by MLTC before distribution. Our Member Education Plan includes our approach to new member outreach, including Welcome Packets and welcome calls; ongoing member education; Member Newsletter; outreach to members identified for Care Management; member engagement tools such as smartphone applications; plans to accommodate the geographic nuances and cultural diversity of the State; community partnerships; and a list of all our Subcontractors engaged in marketing or member education activities. We further acknowledge, as outlined in the Scope of Work, that we will not conduct member education or distribute education materials in provider offices.

Member Education Program Design. Materials used as part of our Health Education program are based on clinical practice guidelines supported by leading academic and national clinical organizations, such as:

- American Diabetes Association
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Child and Adolescent Psychiatry
- National Heart, Lung, and Blood Institute

Our health education materials are easy to understand (no higher than sixth-grade reading level), with appealing graphic elements, and comply with the American Disabilities Act of 1990 (including the availability of Braille and audio tapes) and 508 Accessibility Standards of the Rehabilitation Act to ensure access for those with disabilities. All member materials are written in plain language, and use a friendly tone, active voice, common words, and short sentences. We provide examples when words might be confusing, and we obtain member feedback to ensure clear messaging. To enhance our ability to communicate effectively at a low reading level, our Marketing and Communications staff receive Health Literacy certification through the Institute for Healthcare Improvement.

Health Education Topics. Our wide range of health education topics considers the many needs of our members and aligns with MLTC and NCQA priorities. In addition to identifying utilization trends and listening to member feedback, we actively solicit feedback and ideas from our Member Advisory Committee and local organizations that serve members, such as Public Health Departments, Centers for Independent Living, Area Agencies on Aging, and the Munroe-Meyer Institute. Health education topics include:

- Covered benefits and services
- When to use the ER
- Availability of our 24/7 Nurse Advice Line
- General health and wellness topics
- Preventive care screenings and services
- Healthy pregnancies
- Completing the Health Risk Screening
- Chronic Disease Management programs
- Available website and smartphone-based support programs

Ensuring Cultural Competency. Our member education materials are culturally relevant and are produced in English, Spanish, and other languages upon request. Our cultural competency and disability sensitivity training are extensive. We understand that culture goes beyond race and ethnicity to encompass such issues as poverty and disability. We involve community-based organizations including the NAACP, Nebraska USDA Rural Development, Center for Disability Inclusion,

Japanese Hall and History Project at the Legacy of the Plains Museum, and Tribal representation, in training to ensure staff is familiar with the cultural characteristics of predominant groups. We educate staff about health disparities and barriers members experience in making and keeping appointments and we continually look for opportunities to address cultural issues. For example, members often do not trust unknown phone numbers, mistaking health plan outreach for a call from a solicitor or a bill collector. All outbound calls identify Nebraska Total Care as the caller.

People First Approach. We use a People First approach for all member communications. People's First language puts the person before the disability and describes what the person experiences, not who a person is. We understand that people with disabilities do not "suffer from, struggle to be normal, or fight to overcome their challenge." They are people first. Persons with disabilities have strengths, weaknesses, feelings, and goals in life just like any other person. We recruit member engagement staff that have specialized training and experience in serving a diverse population, including persons experiencing disabilities, homelessness, Intellectual/Developmental disability (I/DD), substance use disorder, or foster care. Additional training upon hire includes Person-Centered Care, Trauma-Informed Care, and Motivational Interviewing.

Ensuring Quality and Maintaining an Effective Member Education Program. The internal approval process for our Member Education Program includes a compliance review and final approval by subject matter experts, and the Communications, Quality, and Compliance departments before submission to MLTC. We have established standards and processes for the development of content and materials to ensure accuracy, inclusiveness, respect for member diversity, and compliance with all MLTC requirements. Content produced by other organizations is subject to the same policies and procedures as internally developed content. As part of our Quality Assessment and Performance Improvement program:

- We review all member educational strategies and materials annually (or more frequently if necessitated by a program change) to ensure our approach is effective, and the content of our materials is correct and does not mislead or confuse our members.
- We seek member feedback during all member interactions to identify where we can improve service delivery and to ensure members understand their health care benefits and other information about the program. During community events, our Community Outreach Coordinators ask members if they have any questions about the materials they received and gather any feedback on how useful and understandable the materials are.

We evaluate member satisfaction data (inquiries, complaints, grievances, appeals, CAHPS results, and plan-administered survey ratings) to identify opportunities to clarify educational materials, programs, policies, or other aspects of our plan.

Innovative Methods to Educate Members

We know that successful education programs require repeated contact attempts at various times of the day on different days of the week. We use multiple modes of communication, including phone calls, written materials, email, texting, mobile applications, web-based, social media, and face-to-face approaches. We believe ***quality health care is best delivered locally.*** We deploy our member education program at the local level to optimize Nebraska-specific member data and member and community feedback, including through face-to-face contact.

Effective Member Texts

By implementing text messaging that links Nebraska Medicaid members to the Member Newsletter, we have increased webpage visits by over 200%.

CHW Member Education Program. We hire our Nebraska-based Community Health Workers (CHWs) from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of each region. They are located across the State to ensure equitable access for urban, rural, and frontier counties. CHWs receive comprehensive training and are an integral part of our Care Management staff, which benefits our members and increases our effectiveness. Through this program, we develop and implement customized, in-person member outreach and education strategies that meet members where they are to encourage informed health and wellness choices. As extensions of our Care Management team, CHWs make home visits to high-risk members we cannot reach by phone and assist with member outreach, coordinate social services, and address SDOH needs.

Community Engagement Education Program. Our Community Outreach Coordinators work alongside our CHWs to provide community-based education that expands beyond direct member contact. For example, through our partnership with the Nutrition Education Program, we actively promote healthy lifestyle activities related to disease prevention and health promotion. At health fairs and our Start Smart for Your Baby® (Start Smart) Showers, we reinforce the importance of a Primary Care Provider (PCP), promote preventive care, encourage personal responsibility and accountability, and answer questions about the Nebraska Total Care benefits. We develop community partnerships and co-sponsor a variety of community outreach and education events throughout Nebraska, such as health fairs and prevention screenings. We also provide Nebraska Total Care materials to our community partners that can be shared with members., increasing the reach of our education program.

Improving Health Literacy and Empowering Members through Technology. Health literacy is a member's ability to understand and act on information to make informed health decisions, such as accessing preventive services and appropriate use of the ED. Multiple studies have concluded that member engagement in care and self-management contribute to optimal health outcomes and quality of life. Health education is a primary driver of increasing health literacy. In today's technology-driven world, the Internet and mobile access are primary sources of health education.

Our website provides mobile-friendly access to Krames Health Library, the Member Portal, our SDOH Mini-screen, and an extensive library of health resources. We also have dedicated significant resources to expanding our capabilities in this area, including the deployment of mobile applications, further described in the following section. Nebraska Total Care provides the following mobile applications:

- **MyNTC** Member Mobile Application
- Our BH Resource Tool, **myStrength**
- 24/7 **Virtual Lactation and Doula Support**
- **Digital Health Connect** for extended Care Management resources and member engagement

Equitable Education throughout the State

We provide health education in multiple formats and facilitate access to these formats for all members across the State. For example, without reliable phone service, some members cannot participate in our phone and text messaging campaigns or access the Internet to take advantage of our member portal. To address barriers such as these, our staff assists members with using the Nebraska Telecommunications Assistance Program and we offer our ConnectionsPlus® program (described below). Member Services will print and mail any member materials upon request. In alignment with our belief that health care is best delivered locally, we have staff providing face-to-face support to members in the communities across the State. Community Outreach Coordinators designate days to be available at community partner offices, such as WIC clinics and food distribution centers, so they are available to members seeking other services.

ConnectionsPlus Program. We implemented our ConnectionsPlus free cell phone program in Nebraska for high-risk members and unhoused members who do not have safe, reliable phone access. Members receive unlimited talk and text services, allowing them to interact with their PCPs or other treating providers, Care Managers, community support organizations, our 24/7 Nurse Advice Line, 911, and 988 (the new national toll-free crisis/suicide hotline). The objective of the program is a reduction in preventable events such as inappropriate ED use or hospital admissions through improved access to health care information and preventive care. We encourage members to contact us, their provider, or other community resources promptly for advice rather than waiting until the next appointment. To date, we have issued more than 160 ConnectionsPlus phones to high-risk members in Nebraska.

Our ConnectionsPlus program empowers members to self-manage their condition and facilitates healthy lifestyles. Our data indicate that ConnectionsPlus members display increased participation in various health screenings and have more provider interactions when compared to similar members that have not been issued a ConnectionsPlus phone. For example, ***Medicaid members who were issued a ConnectionsPlus phone and used it for at least six months demonstrated an average cost savings of $1,062 per month.*** ConnectionsPlus phones can be used in conjunction with our home telemonitoring program, available to high-risk members for whom intensive monitoring is necessary and the condition is amenable to remote biometric telemonitoring, such as blood glucose levels for a member with diabetes or blood pressure or weight for a member with congestive heart failure.

Examples and Descriptions of Our Member Health Education Materials

We include examples of member health education materials used in Nebraska and other States as **Attachments B.30.A – B.30.C**. Nebraska Total Care and our parent company, Centene, offer hundreds of health education materials. In addition to our Member Handbook, benefits brochure, Member Newsletters (sample in **Attachment B.30.A Sample Member Newsletters**), Member Portal, and mobile applications, we provide postcards, pamphlets, and books. We provide these materials as part of our Care Management program and distribute these materials during community events. Many materials have been endorsed or co-authored by nationally-recognized organizations such as the American Academy of Pediatrics, National Organization on Fetal Alcohol Syndrome, Child Health Advocacy Institute, National Urban League, and American Lung Association (a sample of our Asthma Action Plan is included in **Attachment B.30.B Asthma Action Plan**). We submit all proposed education materials for MLTC approval before distribution.

Award-Winning Health Education Book Series. We share Centene's extensive My Route to Health educational book series, developed with a nationally recognized children's author, with our members and community partners to educate on a variety of health topics. As illustrated in **Table 30.A**, there are more than 60 titles grouped by categories – children, adolescents, adults, and members who are pregnant – members can access to learn more about a health topic. Centene's health education books have earned multiple awards and recognition, including National Health Information Awards. Nebraska Total Care has distributed books to members living in Foster Care, in classrooms participating in physical activity challenges, with our Disease Management and Education Programs, at community health events, and in many other member and community interactions. **Table 30.A.** provides additional detail on My Route to Health series available to members of all ages.

Table 30.A My Route to Health Educational Book Series.

Book Series	Description	Books in Series
Children's Health	Targeting members who are in elementary school, the Children's Health Book Series serves as an introduction to health literacy and focuses on topics that foster healthy habits. For example, The Adventures of Boingg and Sprockette books feature Darby the Wallaby and his friends and focus on obesity prevention and healthy eating, asthma, diabetes, foster care, bullying, and the negative impact of smoking. Our CHWs use several titles in the series at school-based and community events and during home visits to support young members dealing with specific health issues.	32
Adolescent Health	The Adolescent Health Book Series addresses a variety of health issues as a way to facilitate communication with teens. For example, the Real Issues, Real Answers booklet (and related parent guide), provides non-judgmental, sound advice about the issues tweens, pre-teens, and young adults face, such as peer pressure, keeping a positive attitude, healthy behaviors, choices, resumé building, conflict resolution (anti-bullying), conduct for using social media, and personal hygiene. The series includes "Off the Chain: It's All About Asthma" to teach teens and their parents about managing asthma. Our "Off the Chain: Teens & Pregnancy" book was written in collaboration with the National Urban League to provide clear, honest information about the stages of pregnancy and vital issues, such as nutrition for mother and baby, labor and delivery, breastfeeding, baby safety, and what to expect after the baby arrives.	10
Adult Health Series	Centene's Adult Health Book Series includes topics such as nutrition and exercise, and condition-specific subjects like asthma, diabetes, and heart disease.	14
Pregnancy Adult Health	Centene's Pregnancy Adult Health Book Series includes books that educate and guide members who are pregnant. Topics include healthy eating ("Baby Fuel: Filling Your Baby's Tank with the Right Foods"), detrimental effects of substance abuse during pregnancy ("Body Well, Baby Well! Risks of Pregnancy, Drugs, Alcohol, and Smoking"), and general information for expectant moms ("Your Pregnancy"). There is even a book for fathers ("DAD: Little Word, Big Deal").	5

Integration of Physical, Behavioral Health, Pharmacy Services, and Dental Services. Many of our health education materials integrate information about PH, BH, and pharmacy. For example, our Start Smart for Your Baby® (Start Smart) program materials include information about postpartum depression and the Edinburgh depression screening tool that members can complete and return to our Care Management staff. The health materials we provide to members with chronic conditions include education on medication management as it relates to each condition. Our Care Management staff educates members on how PH and BH conditions can impact each other, and they help members coordinate care to align treatment plans across providers. Any member can request Care Management assistance, and providers can refer any member for Care Management. In **Attachment B.30.C My Caregiver Journal**, we include a "My Caregiver Journal," helping caregivers stay organized when it comes to members' integrated care. These journals can be used at doctor visits to document follow-up care, new or changes in prescriptions, and other information.

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 and their families. Our communication strategy includes:

- **Dental 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. We include our "Tips to Keep Your Teeth Healthy" health sheet as **Attachment B.30.D Tips to Keep Your Teeth Healthy.**
- **Follow-up after Emergency Department or Missed Appointments.** We identify members who have used the ED for oral pain or dental-related symptoms and a Care Manager or CHW follow-ups with the member/family. 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.

EPSDT Compliance. We begin educating members on the importance of EPSDT compliance during our initial interactions, including before birth with pregnant members. Our member welcome packet contains educational materials on EPSDT including a magnet that lists the recommended frequency of screenings. Our Member Handbook, website, and Member Newsletter offer information on EPSDT. We use automated proactive outreach manager (POM) calls email, and text messaging to members/parents ahead of every recommended EPSDT appointment, including a "happy birthday" email encouraging them to make an appointment. Our health alerts remind members of the need for EPSDT services. Health alerts are available to members on our secure Member Portal and through our MyNTC mobile application. Health alerts are visible to providers via our Provider Portal and to our Member Services and Care Management staff through their documentation systems, allowing them to assist members in accessing needed care. Our Start Smart program materials include information on EPSDT screenings for infants through the first year of life.

We incentivize members to obtain EPSDT screenings through our My Health Pays rewards program as previously described in our response to Q19 – Value Added Services. Our Notification of Pregnancy (NOP) incentive program, described below, is intentionally structured to encourage NOP submission at least 60 days before the due date to allow for the identification of a PCP for the baby before birth. We include Start Smart materials in **Attachment B.30.E Start Smart for Your Baby Materials** and EPSDT brochures in **Attachment B.30.F EPSDT Brochures**.

Appropriate ED Utilization. We educate members about appropriate ED utilization as part of our new member welcome process. Our welcome materials include our information on the appropriate use of the ED, urgent care, PCP, and our 24/7 Nurse Advice Line, (NAL) and our "important phone numbers" magnet which lists the toll-free phone number for contacting the plan and our NAL. During the welcome call, members learn about the availability of our NAL, how to choose a PCP, and the role of their PCP. Similar information is included service in our Member Handbook, Member Newsletter, and website. We have provided a sample of our "Where to Go for Care'' flyer as **Attachment B.30.G Where to Go for Care Flyer**.

Addressing Maternal and Child Health

Award-Winning Maternity Management Program

Our Start Smart maternity management program has earned multiple awards and recognitions, including:

- Children's Health Award, Best Practices Awards, by MHPA
- Silver Medal at the National Health Information Award
- Platinum Award for Consumer Empowerment (URAC Quality Summit)
- International Community Health Promotion Awards
- Web Health Awards

Use of Prenatal Care Services - Start Smart for Your Baby Program. Our Start Smart program, Centene's award-winning maternity management program, incorporates health and wellness promotion, Care Coordination, and population-based services to improve the health of pregnant members and their babies. This multi-faceted approach to improving prenatal and postpartum care includes wellness materials and supports the appropriate use of medical and community resources (Sample materials in **Attachment B.30.E Start Smart**). Start Smart provides pregnant members with tools to empower them to be active participants in their health care team, including wellness programs, educational information, and access to Care Management. An essential component of Start Smart is the NOP process. The NOP form aims to identify pregnant members early in pregnancy and establish relationships between the member, provider, and health plan staff. Receipt of the NOP triggers the mailing of our prenatal care packet and outreach by a Care Manager. Based on information obtained in the NOP and subsequent assessments, we can stratify and assign a risk score that determines the appropriate level of maternal management. Care Management provides one point of contact for the member based on their need, then engages the full scope of expertise through our team approach.

For most members, their primary Care Manager is a Registered Nurse (RN) with labor and delivery experience; however, when there are other complications such as co-occurring BH needs or SUD, a licensed BH provider may be more appropriate to serve in the primary Care Manager role, with the RN Care Manager providing support. We may also identify pregnant

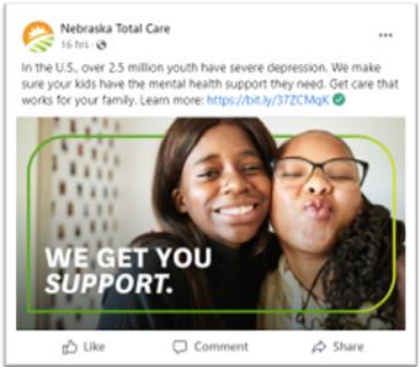
women for outreach through pharmacy data for prenatal vitamins or other indications of pregnancy, reviewing lab data for pregnancy tests, and looking at visits and coding of office visits from OB/GYN providers. Members may access pregnancy and postpartum health information on our website, which includes health videos. Notification of the infant's birth triggers our newborn care packet, which includes information for the mother about the postpartum period and newborn care. Beginning in 2023, members who submit their NOP 60 days before their due date will have the option to choose a car seat, pack 'n play, stroller, or meal delivery service free of charge from Nebraska Total Care. The reward offers up to 10 meals either during pregnancy or post-partum, based on member choice. ***Nebraska Total Care has seen a 20.3% increase in our NOP completion rate from 2018 to 2021.***

Technological Tools, including Social Media and Mobile Technology. Our secure Member Portal offers the informational tools needed to help members take personal accountability for their health care, including important basic information (such as eligibility and benefit information) and helping members understand required tasks (care gap health alerts, health, and wellness reminders). The Member Portal provides members self-service support tools, such as the option to choose or change their PCP online, print a temporary ID card, exchange secure bi-directional messages with our staff, and manage their web account information and communication preferences. As illustrated in **Figure 30.C**, ***Nebraska Total Care members visited the Member Portal nearly 70% more times in 2022 than in 2021, and we are on pace for an 11% increase in portal visits from 2021 to 2022. The number of unique visitors has increased by 13% since 2020.***

Figure 30.C. The increase in Member Portal use since 2020 has included a steady increase in unique (new) users.

Social Media. Nebraska Total Care uses social media platforms, such as Facebook, Twitter, and YouTube to educate members. On our Facebook and Twitter pages, we provide seasonal health tips, information on community events, and guidance on where to find educational materials. One of our recent Facebook posts is included in **Figure 30.D**. On YouTube, we provide member education videos on diverse topics, such as HIPAA, prenatal Care Management, and diabetes self-management (videos are also embedded on our website). In January 2022, we released a video about new year's health goals. ***In 2021, our Facebook page was visited more than 1.47 million times with more than 18,000 engagements (liked or commented), and our YouTube videos were viewed more than 22,100 times.***

Figure 30.D. We use social media platforms, such as Facebook, as another way to educate members.



Member Mobile Application. For our members, we deploy our member-centric MyNTC mobile application, to provide members and their caregivers with the informational resources and tools they need to understand their health coverage and stay engaged in their health and wellbeing. As illustrated in **Figure 30.E**, MyNTC starts with an easy-to-use screen, from which the member can quickly navigate to frequently accessed information, such as their ID card and important telephone numbers. MyNTC is uniformly branded as our mobile application, so users know instantly where to turn for assistance. MyNTC is available free of charge for members, via the Mobile App Resources section of our website, and in the Apple iTunes Store (for iPhone) and Google Play Store (for Android devices). As a mobile development best practice, we continue to release new features to ensure content is kept up-to-date and to keep users engaged. **Table 30.C** lists the current features of the MyNTC mobile application.

Figure 30.E. The MyNTC Mobile Application gives members informational resources to stay engaged in their health.

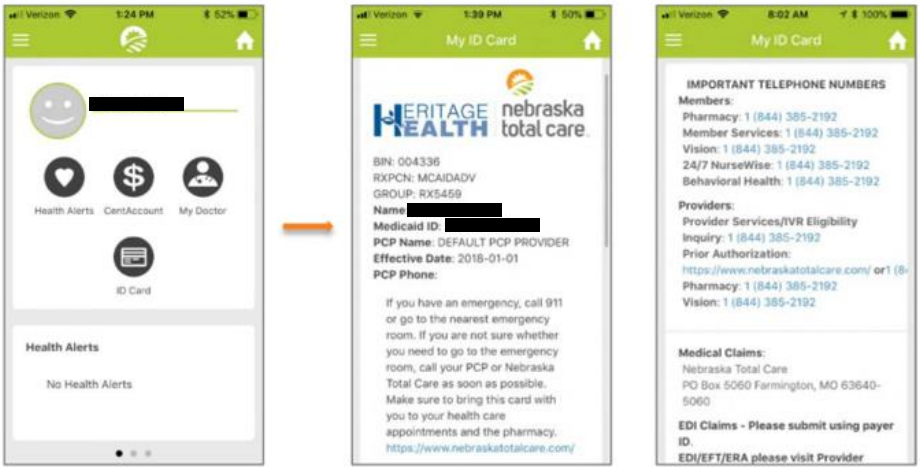


Table 30.C. MyNTC Features and Capabilities Empower Members to Take Control of Their Health.

Content/Function	Description
Member ID Card	Members can securely pull up their member ID card to present at the point of service delivery.
Touch to Call	Members can access contact information for the plan or their PCP. Via "touch to call," they can directly contact their PCP, Member Services, or our 24/7 Nurse Advice Line via a pop-up phone number.
Find-a-Provider	Through the Find-a-Provider feature, members can use MyNTC to search for providers, automatically obtain directions from their location to the provider, and call the provider instantly. A member can locate the nearest ED or urgent care center, obtain hours of operation, and GPS-powered directions, and call the provider.
Health Library	MyNTC has links to hundreds of resources, tools, and podcasts on a variety of health-related topics.
Health Risk Screening	Members can complete a Health Risk Screening (HRS) through the Member Portal and/or mobile application. Once the user completes their HRS, the data can be securely transmitted and loaded into TruCare Cloud for display within the member's clinical care record, triggering Care Management outreach when needs are identified. HRS data is systematically incorporated into our Centelligence reporting and analytics platform for integration with other member clinical data in support of reporting and predictive modeling.
My Health Pays Rewards	Through MyNTC, members can access their My Health Pays rewards information, including account balance and reward points earned to date.
Health Alert Notification	Members can view a health alert when they (or their dependents) have a gap in care. The same health alerts are displayed on the Member and Provider Portals for Care Coordination.

24/7 Virtual Lactation and Doula Support. As an extension of our Start Smart program, we will offer members virtual doula and lactation services. This is provided through a mobile health app to give new and expecting parents unlimited 24/7 access, via video consultation, to an expert network of maternal and infant supports such as certified Lactation Consultants, Pediatric Nutritionists, and Certified Doulas. Doulas enable members to be active participants in their care throughout the birth process. They provide pregnant members emotional support and proactive planning for a healthy birth. Lactation Consultants are professionals who educate new mothers on the health benefits related to breastfeeding and provide guidance to those who choose to breastfeed. Starting in the third trimester, we will conduct outreach and education efforts with all pregnant members. We will encourage them to download the app both for proactive and urgent assistance.

Addressing Maternal and Child Health

Care Gap Health Alerts. Through Centelligence, our award-winning reporting and analytics platform, we generate care gap health alerts regarding preventive health and chronic condition care. These care gap health alerts are provided online, allowing our members and providers to securely access actionable health information via our Member and Provider Portals. These alerts are pushed to our internal Customer Relationship Management (CRM) system. Upon receipt

of an inbound call, the system notifies Member Services staff that the member has an action that needs to be taken (for example, complete a health risk assessment or get a preventive service). Our Care Management staff can see these health alerts in TruCare Cloud, our Collaborative Care Coordination and Utilization Management platform, and educate members about needed services.

Online Health Library and Mental Health Resources. We offer our free online Krames Health Library. It contains information on over 4,000 health-related topics. The library is searchable by topic or keyword and easy to navigate. Materials include books, health sheets, and podcasts. Members can learn about wellness, chronic conditions, plans of care, medications, and many other helpful tips and facts.

Digital Health Connect. 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 (for example, maternal health, diabetes, and other chronic conditions) and provides real-time progress and clinical alerts to Care Managers enabling easy two-way messaging. Each program consists of a targeted curriculum to boost engagement and member self-management. The app gives our Care Management team new tools to reach more members more frequently, make evidence-informed decisions, improve outcomes, and reduce health disparities in alignment with MLTC priorities. ***Digital Health Connect supports frequent member engagement, with 75% of participating members interacting with the program weekly, and an 80% member satisfaction rate.***

For example, the app's diabetes program distills evidence-based, peer-reviewed diabetes care guidelines and literature into a daily mobile to-do list of articles, surveys, encouragements, and reminders. Content is delivered using three modalities:

- Easy-to-consume daily health checklist and educational articles on various aspects of the members' health condition
- Survey questions to identify barriers, measure specific concepts, and drive member engagement with their health
- Encouragement to support members, help them navigate the app, and move them toward health advocacy and health improvement

One of the goals of the app is to meet the holistic needs of members and their evolving communication preferences. With the ability to customize plans of care and program options, track patient analytics from any location, and directly contact members who might otherwise be hard to reach, Care Managers can make evidence-informed decisions, improve outcomes, and reduce health disparities. The app gives our Care Management team new tools to reach more members more frequently and view a member-level dashboard to review and resolve new alerts, insights, messages, and care gaps.

myStrength. Our members can access our online, consumer-directed BH resource tool at no charge through www.myStrength.com. myStrength offers a range of resources to improve mental health and overall wellbeing. Members can access the same resources through the myStrength mobile app. The website offers members the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, and receive motivational ideas and information. We encourage caregivers of members with BH issues to enroll and use myStrength for support and to better understand their family member's BH condition and needs.

Members can participate in myStrength to increase awareness of mental health needs and engage in personalized e-learning programs. For example, to help overcome depression and anxiety myStrength offers tools, weekly exercises, and daily inspiration in a safe and confidential environment. Since we made myStrength available to Nebraska Total Care members in 2021, ***157 Nebraska Total Care members have enrolled, 50% of those enrolled have maintained the same level or experienced less depression (based on PHQ9 assessment), 50% have maintained the same level or experienced less anxiety (based on GAD-7 assessment), and 33% have improved their wellbeing by 10% (based on WHO-5 scores).***

Partnership with Community-Based Organizations for Education and Outreach. In 2021, our Community Outreach Coordinators participated in more than 400 local events across Nebraska, with each event impacting a local population with significant wellness needs. Below is a sample of programs we offer to members and consumers throughout Nebraska. We partner with providers, state agencies, and community-based organizations across the State to provide health education and initiatives on topics that align with the State Health Improvement Plan and the Division of Public Health's Strategic Plan.

Trusted Voices Campaign. Nebraska Total Care is partnering with UNMC and other MCOs on the Trusted Voices campaign to educate the community on service needs, including vaccinations, preventive care, and screenings. UNMC uses MCO data to identify and determine the reason for delayed/absent preventive care, target certain populations, and develop solutions to increase awareness among identified populations.

North Platte Community Recreation Center. Since North Platte does not have a YMCA, we worked with the North Platte Community Recreation Center to provide memberships to their facility. We partnered with the local health department and the recreation center to host a membership sign-up event, which allowed us to educate members on healthy habits, conduct a low-impact exercise class, and distribute healthy snacks. Through this partnership, we conducted a minority

health focus group on nutrition.

Anti-bullying Initiative. We have sponsored ***No One Eats Alone*** at a different school every year. This program teaches students how to make friends and create a culture of belonging. Since 2018 we have partnered with Kearney's Horizon Middle, Gibbon Middle, Omaha's Field Club Elementary, Kearney's Northeast Elementary, and Arapahoe Middle schools.

Digital Health Initiatives for Children. Phoebe's Kids Club offers online resources to encourage the development of healthy habits in young children. So far in 2022, Phoebe's Kids Club has averaged 70 visits per month. We select the best initiatives from Centene's expansive national programs, such as Healthy Hip Hop, our collaboration with H3TV. This Family Fun Fitness Program offers group exercise classes and nutrition education on our website. In addition to Centene's My Route to Health books, they offer activity sheets and a guided school-year journal.

Preparation for Adult Living. Based on experience with children/youth receiving care through the Child Welfare System, including in the juvenile justice system, we offer education for members/caregivers such as Preparation for Adult Living for those nearing transition. We coordinate with service organizations such as the Foster CARE Closet (serving children currently in and out-of-home placement) and Hope Chest (providing services for children transitioning out of child welfare).

Families/Caregivers of Members with Behavioral Illness. Our BH Clinical Trainers offer no-cost webinars on topics like self-harm, effects of trauma, behavioral management, and self-management of co-morbid conditions. Our Tribal Health Liaison also works with our Tribal health providers to conduct webinars in American Indian communities on these topics.

Intellectual and Developmental Disabilities (I/DD) Training and Capacity Building. Through our Pathways program, Centene has worked nationally to develop programs and training to increase provider, family/guardian, and individual capabilities, capacity, and independence within local I/DD systems. In Nebraska, we use Pathways and other best practice and evidence-based programs in conjunction with existing training from organizations such as the Nebraska Association of Service Providers, the ARC of Nebraska, Disability Rights Center, and the Munroe-Meyer Institute, to help increase systemic capacity and opportunities for greater independence and empowerment across the State.

Nutrition Education Program. We partner with the Nebraska Extension Program to provide a variety of nutrition and physical education events. These include physical activity challenges in schools and Head Start programs, wellness education and challenges at Kearney Youth Rehabilitation and Treatment Center, cooking classes both for members and communities, and engagement with seniors at grocery stores to provide food items and recipes.

Heartland Family Service Community Garden. To increase access to food independence, we are working with Heartland to support the utilization of their community garden. We educate participants while working with them on individual and shared plots, provide resources on how to use the product, and supply the My Route to Health cookbook.

Operationalizing Rural Health Framework in Hastings and Bayard. We partner with the ***Fork Farm*** hydroponic garden system at Hastings Middle School. Sixty percent of Hastings Middle School children receive free or reduced-price lunches, and many parts of Hastings are considered a 'food desert.' Fork Farm allows children to learn about growing food and healthy eating and provides opportunities to eat the food they grow; the Fork Farm machine produces 25 pounds of fresh greens and herbs per month that individuals can then plant in-home or community gardens. Nebraska Total Care aims to offer the community of Hastings over 1,000 vegetable and herb plants to be grown by individuals and their families. In 2022, we partnered with the Center for Rural Affairs to identify an additional area of high need—Bayard in western Nebraska, which had recently lost its only grocery store. We are partnering with Bayard Public Schools, which has a very active Future Farmers of America (FFA) program, and we donated and arranged delivery for the Fork Farm. The local FFA will manage the growing and distribution of the plants and produce in the community.

Financial Beginnings. Community Outreach Coordinators are trained by Financial Beginnings to teach financial literacy courses for youth and adults. Programs include key financial concepts, managing debt, financial barriers, taxes, protecting yourself, and using SMART goals. We will provide our first community-based training in the summer of 2022.

Helping 'Liam' Access Appropriate Behavioral Health (BH) Services and Supports. In early 2021, Nebraska Total Care Member Liam was identified as having had several inpatient admissions and frequent utilization of outpatient services related to his BH diagnosis. We enrolled Liam in our BH Care Management program and connected him to an integrated treatment team, consisting of our Service Coordinator, Clinical Liaison, Utilization Management team, and Field Care Management team. The team focused on addressing Liam's BH needs by connecting him to a new outpatient provider and educating him on his long-acting injectable medications and the appropriate use of outpatient vs. inpatient services. The team also linked Liam to community resources for Liam's housing needs and connected him with peer supports for additional support. Through this integrated and targeted approach, the team helped Liam close over 23 care gaps from 2021-2022 related to the Follow-up After Hospitalization for Mental Illness (FUH) and Follow-up After ED Visit for Mental Illness (FUM) HEDIS measures. Additionally, Liam has not had any inpatient admissions to date, he continues to appropriately access and engage in outpatient BH services, and his BH symptoms have remained stable.

RFP 112209 O3

Attachment B.30.A

Sample Member Newsletter

HERITAGE HEALTH | nebraska total care

WHOLE you

2022 Spring Bulletin

Well-Child Checkups

Doctor visits when your child is well helps make sure they are growing, healthy, and safe. Checkups are key to ensuring that children and young adults receive preventive, dental, mental health, developmental, and specialty services.

Well-child checkups are important for your child's health. Your child can look and feel well but still have a health problem. During your child's appointment, their PCP will check:

- Growth
- Development
- Learning
- Ears and eyes
- Diet
- Immunizations
- Test records

Earn Rewards
$10 - Infant Well visits, 1 per visit, ages 0-15 months (up to $60)

Set up well-child visits when your child is:

3-5 days old	12 months old
1 month old	15 months old
2 months old	18 months old
4 months old	24 months old
6 months old	30 months old
9 months old	Annually through age 20

IMMUNIZATIONS

Immunizations are one of the best ways to protect against diseases. Immunization-preventable diseases can be very serious, may require hospitalization, or even be deadly. They are extremely important for all children, babies through adolescence. See the routine childhood vaccine schedule.

LEAD SCREENING

All children should be tested for lead poisoning with a blood test before they are two years old. You or your children may look healthy. But you can still have high levels of lead in your blood. The only way to know for sure is to have a blood test done by a healthcare provider.

SPORTS PHYSICALS

Nebraska Total Care covers required sports physicals for members ages 4-18. Contact the youth's PCP to receive services.

DENTAL CARE

Dental care is also important for children. Children on Nebraska Medicaid have dental coverage. It is not covered by Nebraska Total Care.

The dental plan for Nebraska Medicaid is MCNA Dental. To get information about your dental benefit you can call them. The phone number is 1-844-351-6262, TTY 1-800-833-7352. You can call Monday to Friday, 7 a.m. to 7 p.m.

Start Smart
Our Start Smart for Your Baby® program helps you focus on your health during your pregnancy. Visit NebraskaTotalCare.com to learn more.

Start Smart for Your Baby®

We want to help you and your baby grow healthy and stay healthy. Start Smart for Your Baby® is our program for pregnant women and new moms. It is designed to customize the support and care you need for a healthy pregnancy and baby. It will not cost you a thing.

NOTICE OF PREGNANCY

Schedule a visit with your doctor as soon as you think you are pregnant. Once your doctor confirms that you are pregnant, let Nebraska Total Care know about your pregnancy by filling out our Notice of Pregnancy (NOP) form (PDF).

There are three easy ways to fill out our form:

- Mail in the printed form: Nebraska Total Care, ATTN: SSYB Care Management, 2525 N 117th Ave, Suite 100, Omaha, NE 68164
- Call Member Services at the number on the back of your Nebraska Total Care ID card.
- Log in to your online member portal account.

CARE MANAGEMENT

This is for pregnant women who need extra support. Nebraska Total Care wants to make sure you get the care you need to have a healthy pregnancy and a healthy baby.

Nebraska Total Care's Care Managers are registered nurses, therapists, and licensed social workers who will work with you to answer your questions. As your Care Manager, we can help schedule appointments, give transportation assistance and find support that will help you get well and stay well. We can also help with other behavioral and social services. To reach your Care Management team directly, call 1-844-385-2192 (TTY 711).

TDAP VACCINE

All pregnant women should get a Tdap vaccine between 6 to 8 months of the pregnancy. It is recommended that you get a Tdap vaccine during each pregnancy. The Tdap vaccine is a safe way to protect you and your baby from serious illnesses. As a Nebraska Total Care member, there is no cost to you for this vaccine.

PRENATAL VISITS

Regular doctor visits will be a part of your life when you are having a baby. It is important to go to all of your prenatal visits, even if you are feeling good. Your prenatal visits will happen:

- During the first 32 weeks (Every four weeks)
- From weeks 32-36 (Every two to three weeks)
- From week 36 until delivery (Once per week)

BREASTFEEDING

Breastfeeding has many health benefits for babies. We will give a free electric breast pump to any new mother in our plan. You can ask for your breast pump at the start of your 37th week of pregnancy, until 45 days after your baby is born. Call Nebraska Total Care at 1-844-385-2192, Relay 711.

POSTPARTUM VISIT

Be sure to set up an appointment for your postpartum visit. It should take place within 10 weeks after you deliver. During this visit, your doctor will check on how your body is healing.

Start Smart for Your Baby

HERITAGE HEALTH nebraska total care

WHOLE you | Know Where to Go for Care

You want to take good care of yourself and your family. Part of this is knowing where to go when one of you is hurt or sick. Read on to learn more about the treatment you need for different issues. This way, you can get the right care at the right place and the right time.

24/7 Nurse Advice Line

Medical experts can answer your health questions and help set up doctor visits. Use this option if you need help caring for a sick child or to know if you should see your PCP.

Primary Care Provider (PCP)

Your PCP is your main doctor. If you don't need medical care right away, you can call the office and schedule your visit. This kind of care is for when you need a vaccine, a yearly checkup or help with colds or the flu. You may also visit for health issues like asthma or diabetes.

In-Network Urgent Care Center

Go here if your doctor's office is closed and you need care for a health issue that is noncritical. This includes flu symptoms with vomiting, ear infections, high fevers and sprains.

Emergency Room (ER)

Consider all of your options before you go to the ER. This care option is for issues that are life-threatening. This includes:

- broken bones
- bleeding that will not stop
- labor pains or other bleeding (if pregnant)
- drug overdose
- ingesting poison
- bad burns
- convulsions or seizures
- trouble breathing
- sudden inability to see, move or speak
- chest pains or heart attack symptoms
- gun or knife wounds

Need a ride to your appointments? Request a ride with the MTM Link mobile app.

Care Management

Care Management can be helpful if you have a condition that needs special care. Nebraska Total Care offers one-on-one assistance to members who need extra help to be as healthy as possible.

Care Management could be helpful to you if you:

- Have a life long illness like asthma or diabetes
- Are at risk for a serious condition like Sickle Cell Anemia or HIV/AIDS
- Have a behavioral health need
- Have a child with special needs
- Have a developmental or physical disability
- Have some other special healthcare need

Call Member Services at 1-844-385-2192 (TTY 711).

Community Health Services

The Community Health team is trained to help you get your health needs met. Community Health workers can guide you to better health. We help members:

- Find doctors, specialists, or other providers
- Complete health information forms
- Provide health coaching
- Find community supports
- Arrange needed services

Take the Social Needs Self-Assessment

Measuring Quality of Care

We want to improve the health of all our members. Our Quality Improvement program helps us do this. We check how we are doing by setting goals for quality. We also review the quality and safety of our services and care. We review care provided at all levels, including emergency care, primary care and specialty care. We also make sure we are helping members with different ethnic, cultural, religious and language needs.

We do a member survey every year. The survey is called Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The results show us how members feel about Nebraska Total Care. It shows us how they feel about providers. We use the results to help improve care. The areas we are trying to improve the most are:

- **Doctor Showed Respect and Explained Things**: They are treated with courtesy and respect. Explaining health issues in an easy way.
- **Smoking Advice**: Advising smokers/tobacco users on how to quit. Discussing medications and plans that would help.

There is a tool that sets goals for health plans. The tool is called the Healthcare Effectiveness Data and Information Set, or HEDIS®. Every year, Nebraska Total Care will be measured on HEDIS goals. This will tell us where to do better. Nebraska Total Care reviews the services members got. We will use this information to set goals to improve healthcare for our members.

Below are the projects for improvement:

- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder** Who Are Using Antipsychotic Medications
- **Assisting members after a hospitalization** to follow the discharge and follow up plan

One group that looks at our plan is called National Committee for Quality Assurance Accreditation (NCQA®). They check to see if we meet their rules. If we do, they say we have "accreditation." Nebraska Total Care received 4 out of 5 overall in NCQA's Medicaid Health Plan Ratings 2021.

Learn more and see how we're doing at NebraskaTotalCare.com. You can also ask for a paper copy of the latest quality improvement report. Call 1-844-385-2192 (TTY 711).

Need Legal Help?

Nebraska Free Legal Answers is an online legal advice clinic. You can post a civil (not criminal) legal question to be answered by volunteer attorneys. You can ask legal questions on topics like Family, Divorce, Custody, Housing, Eviction, Homelessness, Consumer Rights, Financial, Employment, Unemployment, and Education.

Nebraska Online Legal Self-Help Center has information and links to legal resources to help you represent yourself in Nebraska Courts.

What You Need to Know Before Going to Court

- Dress as you would for an important event.
- Do not wear T-shirts or clothing with messages.
- Be polite, no matter what is said in court.
- Be on time for court.

HERITAGE HEALTH nebraska total care

WHOLE you

Cancer Screenings: Cervical, Breast, Colon

When you hear the word self-care, what do you think of? For some, self-care means getting a full night's sleep. For others, it means taking time to exercise regularly. One thing we can all agree on is that cancer screenings are an important part of self-care.

Cervical Cancer

Cervical cancer happens when cells in the body change and grow out of control. These cells can form lumps called tumors. Cancer that starts in cells of the cervix is called cervical cancer. The cervix is the lower end of the uterus.

Cervical cancer is usually found during a screening Pap test. During a Pap test, cells are taken from a woman's cervix and checked for changes that may be a sign of dysplasia or cancer. This can help find cervical cancer early, when it's easiest to treat. Get a Pap test as often as your healthcare provider suggests.

Breast Cancer

Your entire body is made of living tissue. This tissue is made up of tiny cells. You cannot see these cells with the naked eye. Normal cells grow and divide (reproduce) in a controlled way. They grow when your body needs them, and die when your body does not need them anymore. When you have breast cancer, some cells change or become abnormal. These cells divide quickly, do not die when they should, and can spread into other parts of the body. Breast cancer can start in different tissues in the breast.

Colorectal Cancer

Colorectal cancer starts in cells in the colon or rectum. It is 1 of the main causes of cancer deaths in the U.S. But when it is found and treated early, the chances of a full recovery are very good. It needs to be found when it is still small and has not spread. This cancer rarely causes symptoms in its early stages. Because of this, screening for it is important.

These screenings are available to Nebraska Total Care members at no cost. Take time to care for yourself by talking to your doctor about which types of cancer screenings are right for you.

Screening	Who	When
Cervical cancer	Women ages 21-65	Pap test every 3-5 years
Breast cancer	Women ages 50-74	Mammogram every 2 years
Colon cancer	Women ages 50-75, Men age 50 or older	Stool DNA test (every 1 to 3 years) Colonoscopy (every 10 years)

YOUNG WOMEN: Chlamydia is the most common sexually transmitted infection in the U.S. Experts advise a yearly screening for sexually active females younger than age 25.

Medication Safety

Take all medications correctly. Read the label on your medicine bottle and follow the instructions carefully.

- Do not take prescriptions meant for others.
- Do not share your prescriptions with anyone else.
- Do not mix with alcohol, sleep-aids, or anti-anxiety medication.
- Do not store medicine where children, pets, or others can get it.

Get rid of old medicine safely. Throw away unused medicine when your treatment is done.

- National Prescription Drug Take Back Day happens in April and October. It provides a safe way to get rid of prescription drugs. Visit TakeBackDay.dea.gov for details.
- You can safely leave unused medication at collection sites. Pharmacies, hospitals, or police stations may have drop boxes or mail-back programs. Call the Drug Enforcement Administration (DEA) at 1-800-882-9539 to find a location.

Nutrition Education Program

The Nutrition Education Program (NEP) in Nebraska helps families on a limited budget make healthier food choices. Choose physically active lifestyles by acquiring the knowledge, skills, attitudes, and behavior changes necessary to improve your health. NEP offers classes to both adult and youth individuals.

NEP offers adult classes that are taught in a series such as meal planning, grocery shopping, physical activity, MyPlate and food safety. Youth classes learn about healthy snacks, MyPlate, breakfast, hand washing, physical activity, etc. Classes are taught in a variety of community sites or virtually.

Please visit the NEP website to learn more and get ideas for your next meal!

Know your benefits

Do you know your benefits? You can find out more about your benefits in the member handbook. If you don't have a copy, we can send you one. Just call us at Nebraska Total Care.

You can also call us with questions about your benefits. We can help you file a complaint. We can also tell you how to appeal a decision.

We offer free interpreter services to members. An interpreter can help you find out more about your benefits. An interpreter can also help you during medical appointments. Call Nebraska Total Care Member Services at 1-844-385-2192 (TTY 711).

2022 Healthy Rewards Program

Earn rewards when you complete healthy activities like a yearly wellness exam, annual screenings, tests, and other ways to protect your health.

- $10 - Adults: Annual flu vaccine, ages 19 and older
- $10 - Adults: Annual checkup with your PCP
- $15 - Women: Breast cancer screening (one every two years)
- $15 - Women: Annual cervical cancer screening
- $10 - Infants: Well visits, 1 per visit, ages 0-15 months, up to $60
- $10 - Children: Annual well-child visit, ages 2-21
- $15 - Adolescents: HPV vaccine for adolescents, for two doses within 12 months, before age 13
- $15 - Notification of pregnancy in 1st trimester (per pregnancy)
- $10 - Notification of pregnancy in 2nd trimester (per pregnancy)

Your My Health Pays® reward dollars are added to your rewards card after we process the claim for each activity you complete. If you are earning your first reward, your My Health Pays Visa Prepaid Card will be mailed to you.

Visit Our Website & Secure Member Portal

Visit **NebraskaTotalCare.com** to create a member portal account. You can use it to:

- Complete your Health Risk Screening
- Complete your Notice of Pregnancy form (NOP)
- Change your primary care provider (PCP)
- Update your personal information
- Print a temporary member ID card
- Find pharmacy benefit information
- Send Nebraska Total Care a message
- See claims and authorization approvals
- Check rewards card balance and more!

Call Member Services

Call **1-844-385-2192 (TTY 711)**. We can help you:

- Find a doctor or change your primary care provider (PCP)
- Get a new Nebraska Total Care ID card
- Understand your benefits
- Change your address and phone number
- Get translation help for medical appointments
- Get transportation to your appointments
- Get a paper copy of anything on our website

You can see authorization approvals on our Secure Member Portal.

RFP 112209 O3

Attachment B.30.B
Asthma Action Plan

My Asthma Action Plan

WORK WITH YOUR HEALTH CARE PROVIDER TO COMPLETE THIS ASTHMA ACTION PLAN

Because asthma often changes over time, it's important that you work with your doctor to track your signs and symptoms and adjust treatment as needed. This Asthma Action Plan can help you better control your asthma. Please fill out the plan and keep it with you.

Each day, find your zone color based on your symptoms. Then, follow the medication steps in the plan, as ordered by your health care provider. Controlling your asthma can help save your life!

My information

My name:	Health care provider name:	Emergency contact name:
Date:	Health care provider phone #:	Emergency contact phone #:
Things that make my asthma worse:		My personal best peak flow:

My asthma severity

While using my controller medication every day,

- ☐ **Intermittent:** I also have to use my rescue medication **less** than 2 days per week.
- ☐ Mild persistent: I also have to use my rescue medication **more** than 2 days per week.
- ☐ Moderate persistent: I also have to use my rescue medication **every day**.
- ☐ Severe persistent: I also have to use my rescue medication **many times every day**.

(continued)

This information is not a substitute for professional medical care. Always follow your health care provider's instructions. Consult your doctor or specialist for questions or concerns about your asthma.

Use traffic light colors to help control asthma

Green is the Healthy Zone. Keep using your controller medication.

Yellow is the Caution Zone. Add rescue medication.

Red is the Danger Zone. Get emergency help now!

MY ACTION PLAN WORKSHEET

Green zone: Healthy

All of these apply:

- ☐ My breathing is good
- ☐ I have no coughing or wheezing
- ☐ I sleep through the night
- ☐ I can do my normal activities
- ☐ I rarely need my rescue medication

Peak flow meter:

_____

(80% or more of my personal best)

Keep using your controller medication every day to stay well and symptom-free

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

15 to 30 minutes before exercise or sports, take:

Yellow zone: Caution

Any of these apply:

- ☐ I am coughing or wheezing
- ☐ I have a hard time breathing
- ☐ I have shortness of breath
- ☐ I wake up at night due to asthma symptoms
- ☐ I have been exposed to something that makes my asthma worse
- ☐ I can do some, but not all, of my normal activities

Peak flow meter:

_____

(between 50% and 79% of my personal best)

Keep using your green zone controller medication every day and use your rescue medication as needed for quick relief:

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

Call your health care provider to get your asthma back in control:

- If you have to use your rescue (quick-relief) medication more than 2 days a week.
- If your rescue medicine does not work.

You should feel better within 20–60 minutes after using the rescue medication:

- However, if your symptoms are worsening or if you are in the yellow zone for more than 24 hours, follow the steps in the red zone!

Red zone: Danger

My asthma is getting worse fast:

- ☐ I am very short of breath
- ☐ My rescue medication is not helping
- ☐ I cannot walk/talk well
- ☐ I cannot do my normal activities

Peak flow meter:

_____

(less than 50% of my personal best)

Take your controller and rescue medications and go to the emergency department or call 911 now!

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

Go to the emergency department or call 911 now!

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RFP 112209 O3

Attachment B.30.C

My Caregiver Journal

My Caregiver
JOURNAL

As a caregiver, people rely on your strength, your understanding, your knowledge and your dependability. But mostly, they count on your care. This journal will give you valuable tips and a place to record vital information, as well as a journal to write down your feelings and concerns.

DISCLAIMER: This book provides general information about caregiving and related issues. The information does not constitute medical advice and isnot intended to be used for the diagnosis or treatment of a health problem or as a substitute for consulting with a licensed health professional. Consult with a qualified physician or healthcare practitioner to discuss specific individual issues or health needs and to professionally address personal medical concerns.

The power to care.

Caring for someone is rarely easy. The balance between taking care of a loved one's health, safety and emotions can be overwhelming. This workbook will give you some tools and resources to help you care for a family member, a friend, a relative or patient.

The key is that when providing care, YOUR well-being should be top of mind. With your health, safety and emotions in check, you'll be better prepared to care for another. So, take care of yourself, give of yourself and define yourself with the power to care.

What's Inside

Health Plan Information

This is your workbook. Use it as a guide and resource for your general caregiving routine. Make the workbook your own by filling out this info.

Primary Health Insurance Provider Type:

☐ Private ☐ Medicare ☐ Medicaid ☐ Other

Company *(if private)*: _____

Member Number: _____

Group Plan Number: _____

Member Services Phone Number: _____

Care Manager/Service Coordinator Name: _____

Care Manager/Service Coordinator Phone Number: _____

24/7 Nurse Advice Line Phone Number: _____

Secondary Health Insurance Provider Type:

☐ Private ☐ Medicare ☐ Medicaid ☐ Other

Company *(if private)*: _____

Member Number: _____

Group Plan Number: _____

Member Services Phone Number: _____

Care Manager/Service Coordinator Name: _____

Care Manager/Service Coordinator Phone Number: _____

24/7 Nurse Advice Line Phone Number: _____

My Care Recipient's Information

Street Address: _____

City/State/ZIP: _____

Phone: _____

Email Address: _____

Date of Birth: _____

Employer: _____

Employer Phone: _____

Primary Care Doctor: _____

Primary Care Doctor's Phone: _____

Specialist Doctor: _____

Specialist's Phone: _____

Specialist Doctor: _____

Specialist's Phone: _____

Attendant Care Provider: _____

Attendant Care Provider Phone: _____

Respite Care Provider: _____

Respite Care Provider Phone: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Non-emergent Medical Transportation Name: _____

Non-emergent Medical Transportation Phone: _____

Emergency Contact Name & Phone: _____

Secondary Emergency Contact: _____

The Basics of Caregiving

CAREGIVER:

Caregivers are broadly defined as family members, friends or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.

Maybe you've trained to be a caregiver, with completed coursework and professional certification. You may have a healthcare background and have made it your working life to tend to the needs of others.

Most likely you're new to the role of caring for a family member or friend who can no longer care for him or herself. If so, we hope you find this workbook helpful as it guides you through some of the concerns you might come across.

Providing care for a person is rarely easy. The time spent caring for someone who can't care for him or herself can drain you physically and emotionally.

But if you're the type of person willing to give of yourself to help someone else, this book might help.

Who can be a caregiver?

- A parent for a child
- A child for an older or disabled parent
- A spouse
- A niece, nephew or grandchild
- A family friend
- A neighbor
- A hired professional healthcare worker
- You or anyone else

Caregiver Basics

As a caregiver, you may share in the responsibility of someone's well-being. You may provide basic functions for a person in need, such as making meals and feeding, bathing, grooming, walking or other daily routines.

What is the care recipient's primary disability or chronic condition?

What supportive services or accommodations are needed?

Signs of the Times

If you suspect that your care recipient may be at the point where he or she needs some extra care and attention, keep an eye out for these possible warning signs:

» The house is messy and in a bit of disorder

» Bills are unpaid, and mail is piled up

» Dirty dishes are piling up in the sink

» Food is spoiling or has expired in the refrigerator

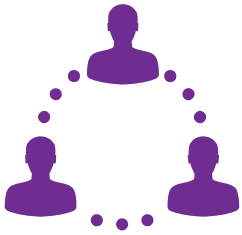
» Trash is piling up

» Plumbing issues are causing odors

Issues like these could signal early signs of depression, dementia, vision and mobility problems. Look for these signs on your visits and get involved if any exist.

Roles of a Caregiver

As a caregiver, you wear many hats: doctor, nurse, lawyer, secretary, accountant, chauffeur, cook, housekeeper and social worker. Your duties may include:



» Keeping track of information on your loved one's condition, treatment and care

» Monitoring your loved one's health

» Helping your loved one with his/her needs

» Helping your loved one make choices about his or her health

» Handling your loved one's emotional needs

» Keeping track of financial dealings on behalf of your loved one

» Planning for your loved one's future care and treatment

Relationship Issues

Getting to know your care recipient is important in providing the kind of care he or she needs. Your relationship may intensify during this time, in good and bad ways.

The secret to success is that it is really about the two people taking care of each other during a difficult time. It's all about give and take. Realizing this will lead to a relationship that thrives. Be gentle, be caring and be understanding.

Why We Do It

Caregiving provides many positive experiences for the caregiver. We feel good about ourselves when we are useful, especially by helping others who cannot care for themselves. We may also see this care as a way of paying back our parents for taking care of us as we were growing up. We're motivated by the belief that we're doing the right thing. And we are.

Use the journal in the back of this book to explore your own reasons for caregiving and the feelings that go along with those reasons.

Caregiving isn't without challenges. When asked, caregivers give examples of stress like these:

» Loss of privacy

» Limits on free time or a social life

» Less time for other family members

» Giving up vacations, hobbies or favorite activities

» Physical and mental exhaustion

» Frustration with not making progress with care recipient

» Financial strain

What do you think could become a problem for you during caregiving?

Communicate

Your care recipient may worry about being a burden, taking up your time and asking too much of you.

Create productive communication by doing these things:

» Show respect

» Watch what you say – try not to use phrases like "You never..." or "You always..."

» Listen to the feelings of your care recipient with compassion

» Build and encourage two-way conversations

» Allow him or her to show independence – your loved one has a right to his or her dignity, so allow him/her to do things in his/her own way

» Speak in ways that support the abilities of your loved one

» Be reassuring when talking to your care recipient

» Notice fears and react in a positive manner

» Work through disagreements to reach a solution

» Set aside time each day when your care recipient knows you have the time and energy to listen

Respect Privacy

Imagine having to bathe and dress the person who bathed and dressed you when you were young. This role reversal can be hard when you're caregiving for your parent. Your elder may withdraw or become angry over the situation. You both may be embarrassed. Have a professional attitude when touching your older family member's body. Slow down and describe what you are about to do. Taking a more relaxed approach will feel less like you are invading personal territory.

10 Ways to Make Things Easier

1. **GET READY:** Learn what is expected of you. Figure out your schedule and how much time you can devote.
2. **GET ORGANIZED:** Organize medical and legal info and keep it up-to-date, in order and easy to find.
3. **GET SUPPORT:** Seek information and advice from other caregivers and support groups.
4. **GET TALKING:** Learn the best ways to communicate with the doctors and healthcare team.
5. **GET HELP:** Take help from others who offer it. Don't be afraid to ask for specific tasks.
6. **GET HEALTHY:** Take care of your own health so you are strong and well enough to care for another person.
7. **GET REST:** A good night's sleep every night and regular breaks during the day will help you concentrate and have the energy to provide for others.
8. **GET HAPPY:** Depression can be an issue when caregiving for another. Watch for signs and seek professional help if you need it.
9. **GET THE LATEST TECHNOLOGY:** Caring can be easier if you're open to using technology. Personal computers, tablets and smartphones can keep you connected to information, healthcare teams, pharmacies and the health plan.
10. **GET TO KNOW YOURSELF:** You're now doing one of the toughest jobs there is. Figure out what makes you tick and how understanding yourself can make you a great caregiver.

5 WAYS TO
Keep Yourself Healthy

Without guilt, you must take care of yourself. If you are not well-rested and healthy, you cannot tend to the healthcare needs of others. The people who count on you want you to be fit and well. Follow these steps to keep your own health and well-being as an important part of your caregiving plan.

1 SLEEP WELL

Don't cut back on your sleep schedule. Trying to get more done by sleeping less rarely works. You need more sleep than you think you do. Eight hours a night is normal. Cheating yourself of this precious downtime means:

- Your mood could change
- Your energy level may reduce
- Your productivity could go down
- Your stress may be greater
- Your ability to handle stress may weaken

Sleep Chart:

DAY / DATE	HOURS SLEPT	HEALTH / MOOD *the following day*

Make copies of this chart or use a journal page to continue.

2 EXERCISE & STAY ACTIVE

Exercise has many benefits. Relieving stress and making moods better are a couple of the benefits. It may be hard to motivate yourself to exercise after a demanding and stressful caregiving shift, but it will help you feel better. Regular exercise will boost your energy level and may help you be less tired.

Try to exercise for at least 30 minutes each day. Find time in your schedule. It may be when you get up in the morning, during a lunch break, before dinner or later in the evening.

3 EAT WELL

Fuel your body with the best things to give you lasting energy:

- Fresh fruits
- Vegetables
- Whole grains, like brown rice or oatmeal
- Lean proteins, like fish, chicken, eggs or beans
- Healthy fats like nuts and olive oil

Sugar and caffeine may seem like they provide energy, but they don't last. The energy rush crashes quickly, leaving you more tired.

Healthy Foods Chart:

DAY / DATE	TIME	HEALTHY FOODS EATEN

4 SEE YOUR DOCTOR

Make it a point to keep all of your doctor appointments, follow his or her instructions and take your prescribed medicine and vitamins. Know your boundaries and don't try to do too much. To care for a loved one, you first have to get your own health in order.

Work with your doctor to fill out this wellness chart. Compare your current numbers to your ideal numbers and work toward getting closer to those ideals.

Wellness Chart:

My ideal blood pressure:	My current blood pressure:
My ideal LDL cholesterol:	My current LDL cholesterol:
My ideal HDL cholesterol:	My current HDL cholesterol:
My ideal triglyceride level:	My current triglyceride level:
My ideal weight:	My current weight:
My ideal amount of time staying physically active:	My current amount of time staying physically active:
My ideal number of fruits and vegetables each day:	My current number of fruits and vegetables each day:

5 RELAX AND MEDITATE

Setting aside a time to unwind and meditate can be a great stress reliever. If you don't have a block of time, even just a few minutes in the middle of your day can get stress levels under control. Practice a routine of deep breathing, clearing your mind and focusing on positive thoughts. Consider adding yoga or stretching to relax even more.

Repeating phrases or mantras may help you reduce stress and bring yourself back to calm. Here are some examples to get you started:

» In every moment, peace is a choice.
» All is well.
» I did well. I don't have to be perfect.
» I will stay calm and carry on.
» I surrender and let go.

Keep Safety in Mind

Safety for your care recipient and yourself should always be a main concern. For frail older adults and those with Alzheimer's disease and dementia, everyday things can pose problems.

Check that elderly care recipients are wearing appropriate shoes with non-slip soles.

Help your older adult prevent falls by making sure he/she:

» Exercises regularly.

» Asks the doctor or pharmacist to check for medications that may cause side effects, such as dizziness or drowsiness.

» Sees an eye doctor at least once a year and updates his/her eyeglasses prescription.

» Takes out all tripping hazards from the home.

» Improves lighting in the home and adds grab bars and rails.

Getting calcium and vitamin D from food or supplements, doing weight exercises and getting screened for osteoporosis can help lower the risk of hip fractures.

BRIGHT IDEA

Put in motion-sensor lights in the bathroom, hallways, stairways and bedrooms.

Safety Check

AT HOME SAFETY CHECKLIST:

All Rooms and Hallways

- [ ] Electrical cords out of the way and secured to walls
- [ ] Carpeting and rugs secured with non-slip backing
- [ ] Walkways free of furniture and clutter
- [ ] All light bulbs and switches working

Bathroom

- [ ] Grab bars mounted in shower and near toilet, if needed
- [ ] Bathroom rug or mat with non-slip backing
- [ ] Shower/bath has non-slip bathmat, secured with suction
- [ ] Free of clutter with enough room to move around
- [ ] Nightlight
- [ ] Shower bench or chair

Bedroom

- [ ] Bedside table with a secured lamp
- [ ] Sturdy chair to sit in while dressing
- [ ] Clear walkway from bed to bathroom

Kitchen

- [ ] All needed items reachable without using a stool
- [ ] No cracks or edges in kitchen floor
- [ ] Place to sit when making food
- [ ] Electrical cords away from water sources

Stairs

- [ ] Free of clutter
- [ ] Handrails secured and at the right height
- [ ] Room to move at top of stairs
- [ ] Well-lit stairways with switches at top and bottom
- [ ] All carpeting secured on steps

Other Safety Tips

- When not in use, store clothing, bedding and other items where they can be reached with ease.
- Place brightly colored tape on the edge of each step. This will signal you're at the drop-off point.
- Make sure all floorboards are even.
- Put a liquid soap dispenser in the shower. Slips and falls can happen when trying to pick up a dropped bar of soap.
- Make sure the water is set at a safe temperature (120°F or lower).
- Make sure items used often are placed within reach.
- Lock up cleaning supplies or flammable liquids.
- Keep a first aid kit in an easy to find place.

BRIGHT IDEA

Make sure a lamp and phone are beside the bed of your care recipient.

Keeping It All Together

As a caregiver you will need to keep all forms and info organized and at your fingertips at all times. Fill out these forms and keep them with you. Keep this info private, to be shared only with your care recipient's healthcare team and close family members.

MEDICATION LOG

Use this log to keep track of your care recipient's medicine schedule. Share this list with your loved one, family members and healthcare team so all know of the medicines taken and the schedule for taking them.

Patient Name: _____

Date of Birth: _____

Local Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

Mail Order Pharmacy Phone/Website: _____

Over-the-Counter Medications

Allergy Relief/Antihistamines: _____

Antacids: _____

Aspirin/Other Pain or Fever Relief: _____

Cold/Cough Medicines: _____

Diet Pills: _____

Herbal Supplements: _____

Laxatives: _____

Sleeping Pills: _____

Vitamins/Minerals: _____

Other: _____

Prescription Medications

	MEDICINE 1	MEDICINE 2
MEDICINE NAME		
DOSE		
WHEN TO TAKE		
WHY IS IT TAKEN?		
START DATE		
END DATE		
PRESCRIBED BY		
SIDE EFFECTS OR DANGER SIGNS		

	MEDICINE 3	MEDICINE 4
MEDICINE NAME		
DOSE		
WHEN TO TAKE		
WHY IS IT TAKEN?		
START DATE		
END DATE		
PRESCRIBED BY		
SIDE EFFECTS OR DANGER SIGNS		

Prescription Medications

	MEDICINE 5	MEDICINE 6
MEDICINE NAME		
DOSE		
WHEN TO TAKE		
WHY IS IT TAKEN?		
START DATE		
END DATE		
PRESCRIBED BY		
SIDE EFFECTS OR DANGER SIGNS		

	MEDICINE 7	MEDICINE 8
MEDICINE NAME		
DOSE		
WHEN TO TAKE		
WHY IS IT TAKEN?		
START DATE		
END DATE		
PRESCRIBED BY		
SIDE EFFECTS OR DANGER SIGNS		

Health History

Check the items that apply to your care recipient's past or present state of health.

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes-Type I
- ☐ Diabetes-Type II
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ Hemodialysis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Intellectually Disabled
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Stomach/Intestinal Problems
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Other: _____

Lifestyle

Smoking: ☐ Yes ☐ No

Packs per day: _____

Number of years: _____

Alcohol: ☐ Yes ☐ No

Drinks per week: _____

Number of years: _____

Allergies

List all food, medication, environmental and other factors to which your care recipient may be allergic.

ALLERGEN	REACTION	LAST INSTANCE	TREATMENT

The most common allergy triggers:

- ☐ Animal dander
- ☐ Certain foods
- ☐ Certain medications
- ☐ Dust mites
- ☐ Insect stings
- ☐ Latex
- ☐ Mold
- ☐ Pollen

Advance Directives

Explanations of these terms can be found on pages 36-37.

HEALTHCARE PROXY

Name: _____

Phone: _____ Cell: _____ Work: _____

Agent Address: _____

Agent Work Address: _____

Document Location: _____

Document Contact Name: _____ Phone: _____

LIVING WILL

Document Location: _____

Document Contact Name: _____ Phone: _____

POWER OF ATTORNEY

(Fill in the information for the person with Power of Attorney)

Name: _____

Phone: _____ Cell: _____ Work: _____

Agent Address: _____

Agent Work Address: _____

Document Location: _____

Document Contact Name: _____ Phone: _____

Fitness for You

Caring for someone else can be time-consuming and exhausting. Spending your free time exercising might seem like the last thing on your list. But it just might be the best thing for your body. Exercise can:

» Keep you from getting sick

» Help you sleep better

» Give you energy to last through the day

» Lower blood pressure and cholesterol

» Lower stress

» Make you a better caregiver

If exercising feels more like a chore, you're much less likely to do it. The good news is: exercise can be easy and fun. It doesn't have to be a full gym workout five times a week.

FIND A FITNESS FRIEND

Pick a friend who has a lot of energy and you enjoy being around. Motivate each other to develop a fitness routine and stick to it. Have fun while you walk, jog, bike or work out.

TRY A GROUP FITNESS CLASS

Many parks and community centers have fitness activities. Look for classes that teach yoga, tai chi, swimming, step aerobics and even martial arts. You'll meet new people, learn new things and improve your overall wellness.

DANCE

Dancing can keep you active and fit. Try ballroom dancing, square dancing or salsa dancing. Dance helps your balance and builds your endurance. And it's fun.

GET ACTIVE WITH THE KIDS

Grab your kids and go for a hike, play basketball, get to the park and be active. They need exercise as much as you do. Hold friendly competitions each week and get everyone involved.

TRY A TEAM SPORT

Softball, bowling, volleyball and tennis teams form regularly. Join one and stay active as you compete.

TURN CHORES INTO FITNESS

Activity comes in many forms. Gardening, raking leaves, mowing the grass, shoveling snow, grocery shopping and washing the car burn calories and keep you active and moving.

REMEMBER: Exercise is vital for caregivers.

Set a goal of 30 – 40 minutes of moderate exercise three or more times a week.

Always talk to your doctor or healthcare team before starting any exercise program.

My Exercise Log

DAY / DATE	TIME OF DAY	EXERCISE	LENGTH OF TIME (REPETITIONS)

My Exercise Log

DAY / DATE	TIME OF DAY	EXERCISE	LENGTH OF TIME (REPETITIONS)

Dealing with Stress

As a caregiver, there are a lot of demands on you physically, mentally and emotionally. You may feel the pressure and stress of your situation, and think you are in over your head with little or no control. Watching for the signs of stress can help you better handle it.

SIGNS OF CAREGIVER STRESS

Check the ones you've experienced yourself since serving as a caregiver:

- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Tiredness/run down feeling
- ☐ Sleep problems
- ☐ Short temper
- ☐ Problems focusing
- ☐ Resentful feelings
- ☐ Drinking more
- ☐ Smoking more
- ☐ Eating more
- ☐ Neglecting duties
- ☐ Health problems
- ☐ Cutting back on free time activities

What other signs of stress have you experienced?

Rest, Relax, Recharge

It's essential to switch off your caregiver mode and relax. Stress and burnout are real risks.

It's easy to find ways to relax that won't cost a lot of money. There are many little things you can do to reduce caregiver stress:

- Take a long bath
- Take a walk
- Bake a favorite dish or dessert
- Read a relaxing book
- Browse the library
- Go see a movie
- Plant some flowers or do some gardening
- Practice yoga
- Talk to a friend
- Listen to soothing music in a low-lit and comfortable place

What other relaxing activities do you enjoy that serve to de-stress you?

Ask for Help

You can't do this alone. And you shouldn't have to. Trying to tackle all the duties and burdens of caring for a loved one on your own won't work.

» Let those around you know you need help.

» Spread out the duties and get as many family members involved as you can. Delegate duties: someone to shop for food; someone to see to the finances; someone to set up appointments; someone to oversee medical concerns, etc. Set up a schedule and assign times and tasks.

» Don't say no to help when offered by a family member or friend. Many people will want to help, and you'll feel better by taking it.

» You can't control every part of your care plan. Let people help and don't micro-manage their efforts. That can harm their desire to help.

» Make a contact list of those you think will be willing to help.

» Create a schedule and document your loved one's likes and dislikes and regular routine.

My helper resources:

NAME	PHONE	TASKS

Take a Break

You owe it to yourself. Your loved one most likely needs the break, too. Add breaks to your schedule and see that you take them. You'll be a better caregiver by giving yourself rest and time to do the things you need and want to do for yourself.

» Set aside at least 30 minutes of "Me Time" each day. This is time to do what makes you feel good, relaxed and unstressed. Enjoy this time without guilt and make it a priority in your day.

» Raise your spirits while you lower your blood pressure. Take a long candle-lit bubble bath. Read a magazine. Anything that relaxes you and makes you feel special will go a long way in defeating stress.

» Laughter is a known stress buster. Watch a funny movie or TV show. Read a funny book. Talk to a friend who knows how to bring out your smile.

» Go shop with a friend. Go for a walk or a drive while others are caring for your loved one.

Make a list of places close by that you enjoy visiting:

Calling the Care Manager/ Service Coordinator

The Care Manager/Service Coordinator is there to support you and is an important part of your care recipient's care team.

While there are many reasons to call, here are some to keep in mind*:

» Change in condition or available support needs

» ER visit

» Hospital admission

» Fall

» Urinary tract infection (UTI)

» Significant injury

» Attendant Provider not providing the agreed upon services

» New diagnosis or medication

» Assistance with finding a provider or changing providers

» Difficulty getting an appointment with a provider

» Potential change in living or work arrangement for the care recipient

» Need for additional caregiver task training

» Durable Medical Equipment (DME) broken or in need of repair

** Nothing within this book should be viewed as medical advice. In the case of a medical emergency, contact your healthcare provider or call 911.*

Managing Caregiving & Work

Millions of Americans juggle the challenges of caregiving with a full-time or part-time job. This struggle for balance can lead to emotional fatigue, physical exhaustion and distraction.

This reality of life has led many employers to be more generous with allowing their workforce to accommodate these demands. Some companies even help with finding community resources, counseling, legal and financial aid and support groups for caregivers. Many offer flex time or leave for their employees caring for a family member in need. If you have a full or part-time job, look into the options your company offers.

Tips for Managing Work and Caregiving:

1 LEARN THE COMPANY POLICIES

Read your employee handbook or speak with someone from Human Resources (HR) to find out the company's policy regarding time off for caregiving. Your company may have an Employee Assistance Program (EAP) that provides benefits for caring for an elderly parent or relative.

2 KNOW YOUR RIGHTS

The federal Family and Medical Leave Act (FMLA) provides eligible workers with 12 weeks per year of unpaid leave for family caregiving. You can't lose your job security or health benefits during these times. Ask your HR department for more info.

3 TALK TO YOUR MANAGER

Tell your manager about your caregiving duties and demands. Ask about changing your work times if your caregiving calls for being away from your job. Be honest about this demand on your time and let your manager know you're willing to work other hours to make up for time lost while caregiving.

4 ASK ABOUT FLEX-TIME

Ask your manager about altering your work schedule, going from full-time to part-time or working earlier or later shifts to accommodate your caregiving needs.

5 STAY ORGANIZED

Try to manage your time as best as you can. Write to-do lists and use calendar reminders. Make a list of priorities and address those first. Don't be afraid to assign tasks to others in the family to help with the caregiving.

6 APPRECIATE

Be thankful and appreciative of your coworkers and managers who help out with your job duties while you are going through these tough times. Offer to take on extra work when you can and help others who may find themselves in a situation like yours.

Legal Matters

Caregiving comes with legal and financial concerns. Make sure you have a working knowledge of these concepts that are put in place to ensure the wishes of your loved one are met.

ADVANCE DIRECTIVES

Advance directives are legal documents that a person writes to tell the healthcare team what medical care and treatment he or she wants or doesn't want. When a person can't speak for him or herself or is too sick or unable to make decisions, these documents make wishes known.

Having advance directives in place for your loved one will make sure he or she gets the care desired, or forgoes the treatment not wanted.

Advance directives cover two types of info:

» The kinds of treatment wanted or not wanted by the family member

» The person put in charge of making healthcare decisions if the family member isn't able to

HEALTHCARE PROXY

This form of advance directive allows someone to name a healthcare substitute. This substitute will make legal healthcare decisions for the person.

Healthcare Proxy Form: A form filled out that gives another person the right to act on healthcare matters for another person. Each state has its own laws and rules about this decision making process. Contact your state's Department of Health to learn the laws and obtain the form that applies for your state.

LIVING WILL

This is a written account of what healthcare treatment a person wants or doesn't want in the future. Again, this document makes sure a person's wishes and decisions are followed, in the event that he or she is not able to make them. Healthcare teams and family members must abide by these legally-binding wishes.

DO NOT RESUSCITATE (DNR) ORDER

This document makes sure the wishes of a person who doesn't want CPR or other life-sustaining methods used if his or her heart or breathing stops are met. Here are some things to keep in mind:

» The DNR order must be signed by a doctor

» If you are a family member caregiver, you may also need to sign the order

» The DNR order will still be in effect, even if no healthcare proxy has been chosen

» There is also an Out-of-Hospital DNR Order that tells emergency staff not to perform CPR if your family member's heart fails while at home. This order must also be signed by a doctor.

Many states have POLST (Physician Orders for Life-Sustaining Treatment) forms that allow for DNR orders to be followed when patients are taken from one healthcare setting to another. See POLST.org for more information and to learn about the laws in your state.

LEGAL HELP

It's wise to speak to a lawyer about these documents and certain financial concerns. A lawyer can help you set up a will or estate plan, as well as give advice on key matters in the life of your care recipient. Legal assistance may be available in your community. Care Managers/ Service Coordinators may be able to connect you to a resource.

DID YOU KNOW?

You may be eligible for tax benefits as the caregiving relative to an older adult in the form of tax breaks or financial help. Check out irs.gov or call 1-800-829-1040 to learn more.

Support Groups

You can't go it alone. But sometimes finding friends, allies and emotional outlets nearby can be a challenge. That's where support groups come in. They're great resources to lean on when you're:

» First becoming a caregiver.

» Learning about caregiving.

» Dealing with the stress of caregiving.

» Sharing your stories and concerns with others who have similar experiences.

Support groups listen to your concerns and problems, giving expert answers to your questions and offering advice. You also listen to others who have issues and need advice. In time, you'll be able to offer advice to others in need. The first thing you'll learn pretty quickly is that you aren't alone in this. Others are in the same situation, with similar problems and challenges.

Some of these groups may be found locally. Others you'll be able to reach online.

HOW SUPPORT GROUPS WORK

Local in-person groups:

» Group members live nearby and meet regularly.

» At each session, you make new friends and speak face-to-face about your concerns while listening to others.

» The meetings offer a social outlet, a chance to get out of the house so you don't feel all alone.

» In most cases, the meetings will be held at a set time and place. Attending regularly will help you get the most out of these support group sessions.

» Learn about local resources from the other local group members. These may include doctors and specialists, health and financial programs or other outlets that could be of help to you.

ONLINE SUPPORT GROUPS

» Group members are from all over the world, meeting online to talk about their concerns.

» You can find these groups online through email, websites, message boards, social media or through recommendations from healthcare providers.

» If you're short on time or can't leave the house, these online support groups may be ideal.

» These groups are most likely easy to reach at any time, offering help when you need it.

» Help will come from a variety of online participants, so finding answers to even your most unique questions and concerns is likely.

You can find a community support group by checking the local phone book, by dialing the United Way at 2-1-1, by asking your doctor or hospital or by calling your Care Manager/Service Coordinator.

MY LOCAL SUPPORT GROUP

Name of Group: _____

Dates/Times: _____

Location: _____

MY ONLINE SUPPORT GROUP

Name of Group: _____

Web Address: _____

My Journal

Use these pages to start journaling about your caregiving experiences. Once these pages are full, keep your thoughts going in another notebook.

Resources for Caregivers

AARP
aarp.org

Eldercare Locator
1.800.677.1116
Eldercare.gov

CAN
(Caregiver Action Network)
Caregiveraction.org

POLST
(Physician Orders For Life-Sustaining Treatment)
POLST.org

Stroke
Stroke.org
1-800-STROKES (787-6537)

Brain Injury Association of America
www.BIAUSA.org

Serious Mental Illness
NAMI.org
1-800-950-NAMI (6264)

Medicare
Medicare.gov

Medicaid
Medicaid.gov

Disability
Disability.gov

U.S. Living Will Registry®
uslivingwillregistry.com

MedlinePlus: End of Life Issues
medlineplus.gov/endoflifeissues.html

Dementia/Alzheimer's
ALZ.org
1-800-272-3900

Family Caregiver Alliance
Caregiver.org
1-800-445-8106

NASUAD (National Association of States United for Aging and Disabilities)
nasuad.org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My Caregiver Journal

SOMEBODY NEEDS YOU.

Caregiver roles can vary, but all exist because someone needs help and care. To support you in your important role, this journal provides tips, resources and tools to assist you in looking after your care recipient and yourself.

Topics in this book include:

- » Caregiving basics
- » Safety
- » Your health and fitness
- » Dealing with stress and burnout
- » Organization
- » Legal and financial matters
- » Support groups and resources
- » And more

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RFP 112209 O3

Attachment B.30.D

Tips to Keep Your Teeth Healthy

Tips to keep your teeth healthy

Dental hygiene is important. Taking care of your teeth can prevent bad breath, gum disease, and tooth decay. But did you know that poor dental health can affect the overall health of your entire body? An unhealthy mouth and particularly gum disease are linked to stroke and heart disease.

Get into a Daily Routine.

You should brush your teeth twice a day. Brushing is one of the easiest ways to keep your teeth healthy. It removes bacteria and cleans off leftover food. Be sure to brush all sides of your teeth and your tongue. Change your toothbrush every three to four months. This helps avoid passing germs from your toothbrush to your mouth. You should also change your toothbrush after you have been sick. Flossing helps get rid of plaque between your teeth. Usually this is where cavities start to form. Slide the floss between your teeth and gently up between the tooth and the gum line for the best results.

Visit the Dentist.

A dental exam removes the plaque that you may have missed with brushing and flossing. Your dentist can catch tooth decay and gum disease early on. If you have already had dental work done it is important you go back to the dentist to make sure everything is still in place. Your dentist will examine your mouth for signs of other health issues like vitamin deficiencies and even diabetes.

What You Eat Affects Your Teeth!

Food and drinks high in sugar can damage the enamel on your teeth, which can lead to decay. Avoid chewy, sticky, sugary foods when you can. If you chew gum, choose sugar free. When you do eat something sugary, rinse your mouth with water or brush your teeth. Drinking water is an easy way to wash away food and bacteria during the day. Foods high in calcium and protein are good for your teeth. Instead of a sugary snack try carrots, almonds, or cheese.

RFP 112209 O3

Attachment B.30.E

Start Smart for Your Baby Materials

HERITAGE HEALTH | nebraska total care

NebraskaTotalCare.com
123864

The Best Start for Your Baby

We have a program for pregnant and new moms. It is called Start Smart for Your Baby®. It is designed to customize the support and care you need for a healthy pregnancy and baby. It is already part of your benefits and won't cost you a thing.

A Program To Meet Your Needs

We provide the following:

- **Information about pregnancy and newborn care.**
- **Community resources** to help you get the things you need during your pregnancy and after your baby is born. This includes food, cribs, housing and clothing.
- **Breastfeeding support** and resources.
- **Professional medical staff** who work with you and your doctor and nurses if you have a more difficult pregnancy.
- **Resources if you are feeling down** during or after your pregnancy.
- Methods to help you **quit smoking, alcohol or drugs.**

Get Started

Go to your doctor as soon as you think you are pregnant.
Call us if you need help finding a doctor.

Let us know about your pregnancy.
Fill out our pregnancy form so we can personalize the ways we can help you.

There are three easy ways to fill out our form:

- **Mail in the printed form.**
- **Call us.**
- **Go online.** Log in to your online member account.

Visit **NebraskaTotalCare.com** for more information or call **1-844-385-2192** (TTY 711.)

HERITAGE HEALTH | nebraska total care

NebraskaTotalCare.com *en Español*

El mejor comienzo en la vida

Tenemos un programa para embarazadas y nuevas mamás. Se llama Start Smart for Your Baby®. Está diseñado para personalizar el apoyo y la atención que necesita para un embarazo y bebé saludables. Ya es parte de sus beneficios y no le costará nada.

Un programa para satisfacer sus necesidades

We provide the following:

- **Información sobre el embarazo y el cuidado del recién nacido.**
- **Recursos comunitarios** para ayudarle a obtener la atención que necesita durante su embarazo y después de que nazca su bebé. Esto incluye alimentos, cunas, vivienda y ropa.
- **Apoyo y recursos para la lactancia materna.**
- **Personal médico profesional** que trabaja con usted y su médico y enfermeros si tiene un embarazo difícil.
- **Recursos si se siente decaída** durante su embarazo o después.
- Métodos para ayudarle a **dejar de fumar, de beber alcohol y usar drogas**.

Comience

Visite a su médico tan pronto como crea que está embarazada. Haga su cita hoy.

Infórmenos sobre su embarazo. Llene el formulario de embarazo para que podamos personalizar las maneras de ayudarle.

Hay tres maneras fáciles de llenar nuestro formulario:

- **Envíe por correo el formulario impreso.**
- **Llámenos.**
- **Vaya en línea.** Entre a su cuenta del miembro en línea.

Visite **NebraskaTotalCare.com** para obtener más información o llame al **1-844-385-2192** (TTY 711.)

THE MOTHER'S GUIDE TO

Pregnancy

Congratulations on your pregnancy! We hope you find this book useful during pregnancy and as you prepare to have your baby. As a reminder, we also provide the following:

- **A 24-hour nurse advice line** (Call us and select "Nurse" at the prompt)
- **Breastfeeding support and resources**
- **Help obtaining a breast pump**
- **Assistance if you are experiencing the baby blues** (feeling sad, overwhelmed, "down" or thinking about harming yourself or others)
- **Methods to help you quit smoking, alcohol or drugs**
- **Over-the-counter (OTC) medicines may be available at no cost to you.** Ask your doctor or call us for more information.

Fill in your Doctor's information here for easy reference:

_____

Doctor's Name

_____

Doctor's Phone Number

Contents

This book is available in other languages. Please call us for more information.

Care Managers

A care manager is a nurse or a social worker who can help you during your pregnancy. He or she can help you find resources and answer questions about your pregnancy and medical care. Write your care manager's phone number here:

_____

If you would like to speak with a care manager, contact your health plan.

Write down questions that you have for your doctor before the visit (refer to the available notes section at the end of this booklet).

First Things First — Prenatal Care

It is important to see your doctor as soon as you think you are pregnant. Studies show that getting prenatal care early can help you have a healthier baby.

YOUR FIRST PRENATAL VISIT

Your first prenatal visit is important to provide valuable information about your baby's health. Your doctor will do blood tests to check on you and your baby. These tests are very important and need to be completed as soon as you find out you are pregnant. Call us if you need help scheduling or getting to your visit. Our phone number is listed on the inside front cover of this book.

REGULAR DOCTOR VISITS

It is important to go to all of your prenatal visits, even if you are feeling well. Your prenatal visits will be:

- Every 4 weeks during the first 32 weeks.
- Every 2 to 3 weeks from 32 to 36 weeks.
- Every week from 36 weeks.

PRENATAL VITAMINS

Your doctor will recommend prenatal vitamins to make sure that you are getting all of the nutrients your body needs to carry a healthy baby. These vitamins have folate to help your baby's brain and spinal cord form well. The vitamins will also have the calcium and iron that your body needs during pregnancy.

FLU VACCINE

Getting the flu when you are pregnant can make you much sicker than other people. It is important to get the flu shot as early as possible during flu season to protect yourself and your unborn baby.

Your baby cannot get the flu vaccine until he or she is 6 months old. If you get the vaccine while you are pregnant, you will pass on antibodies to protect your baby. Flu vaccines are safe for you and your baby. They do not give you the flu. Ask your doctor about getting the flu shot.

TDAP

It is important to get the Tdap vaccine when you are pregnant. Tdap is one vaccine that protects against 3 diseases: tetanus, diphtheria, and pertussis (whooping cough). Pregnant women should get this vaccine after their 20th week of pregnancy, even if they have gotten the vaccine in the past.

Remember

It is important to try and get these vaccines before you have your baby. If you can't, make sure you get them after your delivery. These vaccines are safe even if you are breastfeeding.

Things to Avoid During Pregnancy

As your baby grows, steer clear of things that could harm your baby. Preterm birth, low birth weight, birth defects, miscarriages and stillbirths can all be caused by the things on this list.

SUBSTANCE	WHAT IT DOES TO YOUR BODY AND YOUR BABY
Alcohol	It can cause serious mental and physical defects in your baby. There is no safe amount of beer, wine or booze during pregnancy.
Street Drugs	They can cause birth defects and problems with your placenta. Infections such as hepatitis C and HIV can also be passed on to your baby.
Smoking & Second-Hand Smoke	Smoke can cause very serious health problems for your unborn child. It is also associated with SIDS (sudden infant death syndrome). If you want to stop smoking, ask your doctor or us for help. If you can't quit, cut back as much as possible.
Stress	A little stress is OK, but too much stress has been associated with preterm and low birth weight births. Reach out for help if you are under a lot of stress.
Prescription Opioids	These are strong drugs used for pain, like codeine and oxycodone. One problem with using these drugs during pregnancy is neonatal abstinence syndrome (NAS). Babies with NAS have drug withdrawal after birth. Breathing, feeding problems, and seizures can occur. Try not to take these drugs during pregnancy. If needed, take them exactly as prescribed. If you have been taking opioids for a long time, talk to your doctor. Do not stop them suddenly. Treatment such as methadone or buprenorphine can help you quit opioids safely.
Certain Foods & Drinks	Raw meat or eggs, deli meat, raw or smoked fish, unpasteurized milk and soft cheeses can carry germs that will cause infections in your baby. Deli meats and smoked fish are OK to eat if they are heated. Fish with large amounts of mercury such as shark, swordfish, king mackerel and tilefish should be avoided during pregnancy. Babies exposed to mercury can have brain damage, hearing, and vision problems. Limit canned tuna to two cans per week. Too much caffeine during pregnancy may be associated with preterm birth, low birth weight, and miscarriage.

If You Want To Quit Smoking

- Smokefree.gov or call 1-800-QUIT-NOW

If You Are in an Abusive Relationship

- National Domestic Violence Hotline 1-800-799-2333

If You Need Help with Alcohol or Substance Abuse

- National Council on Alcoholism and Drug Dependence: **1-800-622-2255**
- Federal Substance Abuse and Mental Health Services Administration's Treatment Referral Routing Service: **1-800-662-4357**

"Knowing the items that could harm my baby and me was very helpful. I knew about some of the things, but not all of them."

JANET B.
Mom-to-be

Helpful Hint
Doctors say it is usually OK to exercise while you are pregnant.

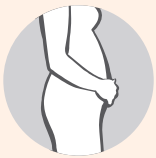
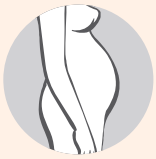
Exercise

Remember to talk with your doctor before starting any exercise program.

- Try to exercise at least 2 to 3 times per week for 20 to 30 minutes each time.
- Drink plenty of water before, during, and after you exercise.
- Avoid lifting heavy weights.
- Avoid exercising outside on very hot days.
- If you are feeling tired or short of breath, take a break. Don't push yourself too hard.

Changes During Pregnancy

During pregnancy, your body goes through many changes. These changes are a natural part of pregnancy.

TRIMESTERS	SYMPTOM	DESCRIPTION	WHAT CAN I DO?
 **FIRST TRIMESTER (1-12 WEEKS)** This is a period of fast growth and development for the baby. The baby has developed all of his or her body parts and organs.	*Feeling Tired*	Most women feel very tired during the first three months. The tired feeling usually goes away by 13 weeks.	• Take a nap or take a few rest periods each day. • Ask family or friends to help you with housework or tasks.
	Morning Sickness	Feeling sick to your stomach. Some may vomit or throw up. It can happen any time of the day — not just in the morning. It usually begins in the first month of pregnancy. In most cases, it gradually goes away by the end of the 13th week and it is almost always gone by week 20.	• Avoid having an empty stomach by eating frequent, small snacks like crackers, toast, pasta, or broth. • Ginger capsules and vitamin B6 can help • Avoid spicy, fried, and greasy foods. • There are prescription drugs that can help.
 **SECOND TRIMESTER (13-27 WEEKS)** The baby continues to grow and develop quickly. By the 22nd week you should be able to feel the baby moving.	*Headaches*	Your body experiences a surge of hormones and an increase in blood volume. This can cause more frequent headaches. They should decrease by the middle of the 2nd trimester when your hormones stabilize.	• Talk to your doctor about any medicines you may be able to take.
	Heartburn	Many women have heartburn while pregnant. Your hormone changes during pregnancy change your whole digestive system. Also your growing womb pushes on your stomach.	• Ask your doctor about antacids. • Eat 5 or 6 small meals. • Wait an hour or two after you eat before lying down. When lying down, prop up your head and back with pillows. • Avoid caffeine in teas, coffees, and colas. Avoid high fat foods, spicy foods, and chocolate.

Understanding these changes can help you through them. Some of the changes are emotional, some are physical, and some are changes to your routine.

TRIMESTERS	SYMPTOM	DESCRIPTION	WHAT CAN I DO?
 **THIRD TRIMESTER (28-BIRTH OR 40 WEEKS)** The baby continues to gain weight and develop important organs like the lungs and increase brain size.	*Back Pain*	You may find you have to lean back to keep your balance as your belly grows. This puts more stress on your back muscles, causing back pain.	• Keep your back straight and bend with your knees when you lift things off the ground. • Wear low-heeled shoes with good support. • Wear a support belt to lift your belly.
	Swelling	Your ankles, feet, and hands may become swollen in the last few months of pregnancy.	• Drink at least 6 to 8 glasses of water a day. • Put your feet up and rest as often as you can. Do this a few times each day.

Eating Right for You and Your Baby

Making healthy eating choices during pregnancy is very important for your baby's health.

- Choose fresh or canned fruits when available.
- Eat fresh or frozen vegetables.
- Eat less fat.
- Go easy on butter, margarine, and fried foods.

10%
OF BABIES
born in the United States are premature.

— Centers for Disease Control and Prevention

Potential Pregnancy Problems

It is important to know the warning signs that indicate you or your baby are at risk. Share all your symptoms with your doctor.

PRETERM LABOR AND DELIVERY

Normal pregnancy lasts about 40 weeks. A baby born before 37 weeks is called a preemie. Since they are not fully developed, they can have the following problems:

Babies born early can have many short-term problems. Because they are not fully developed they can have:

- Breathing problems
- Trouble feeding
- Bleeding on the brain, causing injury.
- Risk of serious and life-threatening infections.
- Behavioral problems
- Long-term issues with their lungs, vision and hearing.

WHAT CAN YOU DO?

If you have any signs of early labor, see your doctor immediately. There may be medicines they can give you to stop the labor.

Know About Risk Factors

There are many known risk factors for preterm delivery.

RISK FACTORS	WHAT SHOULD I DO?
Previous preterm delivery	Talk to your doctor about medicines like 17P or other ways to help prevent another preterm infant.
Pregnant with multiples	Carrying more than one baby means you will need to get extra rest and see your doctor more often.
Certain infections	Make sure you get tested and treated for all of your infections and tell the doctor about any symptoms you may be having.
Substance use	Avoid smoking, drinking alcohol and using illegal drugs during pregnancy.
Short time period between pregnancies	Wait at least 18 months before getting pregnant after your last delivery.
Stress	Serious types of stress caused by things like divorce, a death in the family, losing a job, financial problems, or a lack of social support can lead to preterm delivery. Reach out for help if you are experiencing high levels of stress.

CHRONIC HEALTH CONDITIONS

If you had chronic health conditions before getting pregnant, you could be at higher risk for complications during pregnancy. Some of the conditions that could affect your pregnancy are heart disease, diabetes, high blood pressure, and obesity. Talk to your doctor about the best way to manage these conditions while you are pregnant.

DIABETES DURING PREGNANCY (GESTATIONAL DIABETES)

If you develop high blood sugar during pregnancy, it is called gestational diabetes. High blood sugar in the first trimester can increase the risk of birth defects and miscarriage. During the second and third trimesters diabetes can raise the chance that:

- Your baby will be very large. This can make labor hard, increasing the risk of needing a c-section.
- Your baby may have low blood sugar when they are born.
- Your baby has an injury during birth.

Glucose Screening

If you have a history of high blood sugar during a previous pregnancy, you will be screened for gestational diabetes in the first trimester.

Everyone else should be screened after 24 weeks.

HIGH BLOOD PRESSURE DURING PREGNANCY (PIH/PREECLAMPSIA)

PIH stands for pregnancy-induced hypertension. This is a type of high blood pressure that can happen during pregnancy. It can cause serious health problems for you and your baby. If you are getting PIH, your blood pressure will go up and your body will hold on to fluid.

Signs of PIH

- Your hands, feet, and face are puffy.
- Your vision changes. You may see bright or dark spots.
- You have pain on the upper right side of your belly.
- You have headaches that do not go away with medicine.

If you have any of these signs, call your doctor right away.

BABY BLUES

Feeling the "baby blues" during pregnancy is common. It does not only occur after delivery. Almost everyone feels overwhelmed and unsure of themselves at times when they are pregnant.

If you are feeling sad or worried more often than not, you might have depression. Reach out for help from your doctor, friend, partner, or the national helpline — 1-800-273-TALK (8255) if you think you are depressed. You can also reach out to us or complete the Prenatal Wellness Survey in the front of this packet and mail it in to us. We will contact you by letter or phone regarding your survey and the ways we can help.

What is the Neonatal Intensive Care Unit (NICU)/Special Care Nursery (SCN)?

Most babies are born healthy and stay with their mom after delivery. If your baby is born early or is noted to have other problems, he or she might need to spend some time in the NICU/SCN.

The NICU and SCN are special areas of the hospital. These areas have staff and special equipment to care for high risk newborns.

24-Hour Nurse Advice Line

Call the number on the back of your health plan ID card if you have questions when your doctor's office is closed or you are not sure if you should go to the emergency room.

Can I Breastfeed?
Almost all women can breastfeed! Do not worry if your breasts are small or if you are thin. All shapes and sizes can make the milk your baby needs.

Using Formula
If you use powder formula, ONLY mix it as directed. Diluting the formula with extra water can cause serious problems for your baby.

Bodies burn almost 20 calories to make an ounce of breast milk. If your baby eats 19-30 ounces a day, that is anywhere between

380 to 600 CALORIES BURNED

— Women's Health

Deciding to Breastfeed

Before your baby arrives, it's time to start thinking about if you want to feed your baby breast milk or formula.

BREAST MILK IS GREAT FOR YOUR BABY

Doctors and health organizations agree that breastfeeding is best. You may already know that breast milk is packed with the perfect mix of nutrients your baby needs. Breast milk has special ingredients, like antibodies, that only you can provide.

It is easier to digest. And helps your baby's brain develop. It may even improve your baby's IQ.

It helps protect babies against the following:

- Earaches
- Colds, coughs, and wheezing
- Diarrhea
- Childhood leukemia

It also helps protect against diseases later in life.
Adults who were breastfed as babies have less tendency to become overweight as well as a lower chance of getting the following:

- Diabetes
- Asthma
- Some cancers

BREASTFEEDING A PREMATURE BABY

Breastfeeding is very important if your baby arrives early. You will produce milk that will nourish your baby with extra calories, vitamins, and protein. The live cells in breast milk will help protect your premature baby from infection.

BREASTFEEDING IS GOOD FOR YOU TOO!

- Breastfeeding helps you recover from childbirth.
- Breastfeeding creates a special bond between mother and baby.
- Breast milk is always ready when your baby gets hungry. That means no trips to the store to pick up formula and fewer bottles to wash! You can feed your baby right away in the middle of the night. You will not need to mix formula.
- It protects your health. It also lowers your chance of getting breast cancer, ovarian cancer, and diabetes.
- Did you know that you could burn hundreds of calories a day just by breastfeeding? Breastfeeding can help you get back to your pre-pregnancy weight.
- It is FREE!
- Breastfed babies are healthier so you may have fewer trips to see the doctor.

Before you go to the hospital, learn as much as you can about breastfeeding. You can read books, go to classes, and talk to friends to learn about the benefits of breastfeeding.

Starting Breastfeeding

Now that you have made the decision to breastfeed, here is how to get started right after your baby is born. Your baby will likely be alert after birth and seek the breast.

BREASTFEEDING FOR THE FIRST TIME

If possible, nurse your baby for the first time with skin-to-skin contact within one to two hours after you give birth. This contact has many positive effects for your baby:

- Maintains regulated body temperature after birth.
- Maintains heart rate, respiratory rate, and blood pressure after birth.
- Your baby is more likely to latch on faster during breastfeeding.
- Your baby is more likely to breastfeed exclusively and for a longer period of time.

WHAT IS SKIN-TO-SKIN CONTACT?

You should continue skin-to-skin contact for the first few weeks at home. Here are some tips for performing skin-to-skin contact:

- Wash your hands well before starting.
- Have your baby wear only a diaper.
- Remove your shirt or wear a shirt with buttons. Remove your bra.
- If you have a shirt with buttons, use the open shirt to wrap around your baby. If you're not wearing a shirt, use a light blanket to cover you and baby.
- Sit in a location where you can lean back a bit. Half lying, half sitting is good for your baby's breathing.
- Put your baby against your bare chest. Baby should be facing you, tummy to tummy.
- If you are in a cold room, you may put a cap on baby's head.
- Enjoy this time with your baby for at least an hour.

ROOMING IN

Rooming in means the baby stays in their bassinet in your hospital room. By keeping your baby close, it is easier to learn their cues and notice any early signs of hunger. Feeding when your baby starts to act hungry is called feeding "on demand." Rooming in and feeding on demand have both been shown to help promote successful breastfeeding.

Lactation Consultant

You may have a Lactation Consultant (a specialist in breastfeeding) available to you while you are in the hospital. You may also contact them after you leave the hospital. The International Lactation Consultant Association can also help you find a specialist in your area!

Visit **www.ilca.org/why-ibclc/falc.**

"You and your baby gain many benefits from breastfeeding. Breast milk is easy to digest and has antibodies that protect your baby from infections."

DR. JACK KLEIN
Obstetrician

"I really appreciated the program. I was happy to know I had help when I needed it."

NICOLE R.
Mom-to-be

Gearing Up for Baby

If you haven't already started getting supplies for your baby-to-be, now's the time to start! Use this checklist to help you find the things you need. Ask friends and family members if you can borrow items.

Remember
While it's nice to have these items, love is the greatest gift you can offer your baby. The thing your baby needs most is you!

TO WEAR:

- ☐ Booties or socks
- ☐ Hats
- ☐ Onesies
- ☐ Sweaters
- ☐ Stretch suits with feet
- ☐ Sleepwear, one-piece pajamas, or nightgowns
- ☐ _____
- ☐ _____

FOR BATHING:

- ☐ Baby bathtub
- ☐ Baby lotion for after the bath
- ☐ Baby shampoo
- ☐ Baby washcloths
- ☐ Hooded bath towels
- ☐ Liquid baby soap
- ☐ _____
- ☐ _____

FOR SLEEPING:

- ☐ Bassinet or cradle
- ☐ Crib and mattress
- ☐ Tight fitting crib sheets
- ☐ Small, light receiving blankets
- ☐ Waterproof pads
- ☐ _____
- ☐ _____

FOR EATING:

- ☐ Bibs
- ☐ Bottles and nipples for breast milk or formula
- ☐ Bottle and nipple brushes
- ☐ Burp cloths or cloth diapers for spit-ups
- ☐ _____
- ☐ _____

FOR BREASTFEEDING:

- ☐ Breast pump
- ☐ Lanolin cream to soothe sore nipples (you might be able to get this at no cost with a prescription from your doctor)
- ☐ Nursing pads to wear in your bra (you might be able to get this at no cost with a prescription from your doctor; or try using a sanitary pad cut in half)
- ☐ _____
- ☐ _____

FOR CHANGING:

- ☐ Diapers
- ☐ Diaper pail
- ☐ Baby wet wipes
- ☐ Diaper rash cream
- ☐ Changing pad and table
- ☐ Diaper bag and changing pad to go in your diaper bag
- ☐ _____
- ☐ _____

FOR LAUNDRY:

- ☐ Fragrance-free soap. These are much less likely to bother your baby's skin
- ☐ _____
- ☐ _____

FOR HEALTHCARE:

- ☐ Cool mist humidifier to ease baby's breathing when the air is dry
- ☐ Medicine dropper to measure medicine
- ☐ Nasal suction bulb
- ☐ Thermometer
- ☐ _____
- ☐ _____

FOR TRAVEL:

- ☐ Blankets to cover your baby while you are outside
- ☐ Front pack or backpack to carry your baby in for the first six months
- ☐ Infant car seat
- ☐ Stroller
- ☐ _____
- ☐ _____

OTHER USEFUL SUPPLIES:

- ☐ Playpen
- ☐ Rocking chair
- ☐ Safe toys
- ☐ Safe baby swing (avoid the kind that hangs from a doorway)
- ☐ Pacifiers, if you decide to use them
- ☐ _____
- ☐ _____

Child Safety Seats
Motor vehicle crashes are the leading cause of death among children in the United States. Placing your baby in an age and size appropriate restraint system lowers the risk of serious and fatal injuries by more than half.

Pre-Delivery To-Do List

The wait is almost over. Your little one will be here soon! We know this is a busy time for you, so we want to help you with a checklist of things to do before heading to the hospital.

PREPARING FOR BABY

- ☐ **Choose a doctor for your baby.**
- ☐ Take childbirth classes. These classes can help you and your partner prepare for labor and birth.
- ☐ Take parenting classes. These classes help you learn how to care for your new baby.
- ☐ Tour the hospital where you plan to deliver and pre-register, if possible.
- ☐ Have a plan for when you go into labor (childcare/transportation).
- ☐ Make plans for some help after you get home from the hospital with the new baby.
- ☐ Set up a safe place for baby to sleep.
- ☐ Wash all baby clothes and sheets.
- ☐ Make a meal plan for after you deliver. Ask friends and family to help.
- ☐ Get an approved car seat installed for the trip home. (You will not be allowed to take your baby home without it.) Contact your local firehouse for assistance with installing your car seat.
- ☐ Write a letter to your baby.

PACK YOUR BAG FOR THE HOSPITAL

For Me

- ☐ Insurance card
- ☐ Extra underwear
- ☐ Maternity bra and nursing pads
- ☐ Loose clothes to wear on the way home
- ☐ Nightgown
- ☐ Robe
- ☐ Slippers or warm socks (nonslip)

Toiletries

- ☐ Toothbrush and toothpaste
- ☐ Deodorant
- ☐ Shampoo and conditioner
- ☐ Hairbrush
- ☐ Lip balm
- ☐ Headband or ponytail holder
- ☐ Your own bath towel
- ☐ Contacts or glasses
- ☐ Cell phone and charger

What helps you relax? Here are some ideas other women found helpful:

- ☐ Relaxing music
- ☐ Relaxing lotions or scents
- ☐ Small fan to keep cool

For My Baby

- ☐ Baby blanket
- ☐ Diaper bag
- ☐ Baby wipes
- ☐ Onesie or undershirt
- ☐ Baby keepsake book
- ☐ Outfit for photos
- ☐ Ask your friends and family to bring along a camera to capture baby's first day!

OTHER

_____

_____

_____

_____

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_____

_____

Preparing For Labor & Delivery

Once you get closer to your delivery date, your body will start preparing for your baby's arrival.

FALSE LABOR

Before true labor begins, you may feel your womb tighten up. This squeezing is called Braxton Hicks, also known as practice contractions or false labor pains. Your contractions are probably just practice contractions if they:

- Are not painful.
- Do not have a regular rhythm.
- Are more than 10 minutes apart.
- Go away after drinking two glasses of water or after a short walk.

Practice contractions are OK late in pregnancy.

SIGNS OF TRUE LABOR

There are several signs that you are in true labor. Call your doctor immediately when you notice these signs:

Water breaks

This means that the bag of water around your baby has broken. You may feel fluid coming from your vagina. If you think your water has broken, don't use a tampon, get in the tub, or have intercourse. Call your doctor.

True contractions

Unlike practice contractions, true contractions will get stronger and more frequent over time. You will feel your entire womb squeezing. Some women say they feel like a belt is getting tighter and tighter around them. If your contractions are less than 10 minutes apart, this may mean that true labor has begun.

Back Labor

You may feel pain in your lower back that is associated with the womb contracting (squeezing). This is labor occurring in your back. This pain may spread to your lower belly and could even spread to your legs.

WHAT SHOULD I DO IF I THINK I'M IN LABOR?

- Call the doctor and prepare to go to the hospital.

Once you arrive in the hospital you will most likely:

- Be sent to the labor and delivery unit.
- Register.
- Get checked by a nurse or doctor.
- If you are in active labor, you will be admitted to a room to have your baby!

Managing Pain During Delivery

There are many different medicines for pain control during childbirth. Talk to your doctor about what method is right for you.

IV Pain Medication

Some pain medications can be given through a tube (IV) in your hand or arm. These take the edge off of mild contractions.

Epidural Anesthesia

An epidural is a way to give numbing medicines into the space outside your spinal canal. A tube is placed into this space through your lower back. This is a safe and effective method of pain control.

If you are having signs of labor and are more than 3 weeks before your due date, this is an emergency. You could be in preterm labor. Seek medical attention ASAP.

Medications Your Baby Will Get

Your baby will receive several medications in the hospital to keep him or her healthy.

- ***Eye ointment:*** to prevent eye infections/ blindness.
- ***Vitamin K shot:*** to help your baby's blood clot.
- ***Hepatitis B vaccine:*** to protect your baby from Hepatitis infection.

Vaginal Delivery & Cesarean Sections

Most women will have a vaginal delivery — delivery through the birth canal (vagina). About 1 in 3 babies born in the US is born by Cesarean Section, also known as c-section. Learn about both types of deliveries below.

VAGINAL DELIVERY

Vaginal delivery is the childbirth method most experts recommend for full term healthy babies. It consists of 3 stages:

Stage 1: Labor

Labor is hard work! It is usually the longest part of childbirth. At first, your contractions may feel like strong cramps — sort of like when you have your period.

As labor continues:

- Your cervix slowly opens (dilates).
- Your contractions get stronger, longer, and closer together.

Stage 1 ends when your cervix opens all of the way. It will measure 10 centimeters across. This is when you are completely dilated.

Stage 2: Pushing and Delivery

This stage may last 2 to 3 hours or more. Now that your cervix is completely dilated (fully opened), you may be ready to start pushing. Your contractions move your baby down to the birth canal to the opening of your vagina. You help your baby along by pushing.

Stage 2 ends when your baby is born. Don't be surprised if your baby's head is swollen or cone-shaped from squeezing through the birth canal. It will go back to normal soon.

Stage 3: Delivery of the Placenta

This stage usually begins right after the birth of your baby. It ends when the placenta is delivered.

INDUCED LABOR

Sometimes, the doctor may want to help get your labor started. This is called an induction. According to the American Congress of Obstetricians and Gynecologists (ACOG), labor should be induced only when it is more risky for the baby to remain inside the mother's womb than to be born.

If the doctor recommends an induction, you will get medications to jump start your labor or soften your cervix. Your bag of water may be broken by the hospital staff if it doesn't break on its own. Then you will go through the rest of the stages of vaginal delivery.

C-SECTION

A c-section is a surgical procedure used to deliver a baby through incisions in the mother's abdomen and womb (uterus). C-sections are needed when it is too risky to deliver through the birth canal.

If the doctor recommends a c-section you will receive some anesthesia to numb your lower body, if you did not already receive an epidural. You will probably be awake for the procedure except in the case of an emergency delivery. The doctor will make an incision in your abdomen and womb. Then your baby and your placenta will be delivered through that incision. Your incision will be closed and you will be able to see and hear your baby for the first time.

Elective Deliveries

Elective deliveries are deliveries you plan in advance for convenience. It is important to know why you should not choose to deliver your baby before 39 weeks without a medical reason.

BABIES BORN LESS THAN 39 WEEKS

A normal pregnancy lasts 40 weeks. Babies born even a little early (between 37 and 39 weeks) may require more days in the special care nursery (SCN) or neonatal intensive care unit (NICU). They may also have the following problems:

- Breathing problems.
- Trouble feeding.
- Jaundice.
- Trouble staying warm.
- Lower math and reading scores in first grade.
- Behavioral problems.

WHAT DO I NEED TO DO?

If your doctor recommends an induction or c-section before 39 weeks, ask questions. Make sure you understand the medical reason you are delivering your baby early.

DID YOU KNOW?

A baby's brain at 35 weeks weighs only two-thirds of what it will weigh at 40 weeks. The liver, lungs, eyes and ears continue to grow until 40 weeks.

35 weeks

39 to 40 weeks

Images used by Centene Corporation under license from the March of Dimes.

Tests Your Baby Will Get

Your baby will also receive some **screening tests** before they go home:

- ***Hearing test***
- ***Newborn screening tests:*** a couple drops of blood will be taken from your baby's heel to test for a variety of disorders like hypothyroidism and PKU (phenylketonuria)
- ***Newborn cardiac screen:*** a sensor around your baby's hand or foot will check the infant's oxygen level to screen for serious heart defects.

"You don't know what to expect when you are pregnant. The program provided me with information to calm my worries."

NATALIE R.
Mom-to-be

Heading Home
You are likely to go home 1–2 days after vaginal delivery or 2–4 days following a c-section.

Check with Your Doctor to find out when you can resume sexual and normal activities.

Your Body After Delivery

It is important to see your doctor about 4–6 weeks after giving birth. This visit is called a postpartum visit and is important to make sure your body is healing after delivery. The table below includes some typical symptoms you may experience when recovering from delivery, and some suggestions about how to handle them.

SYMPTOM	WHAT TO EXPECT AND WHAT YOU CAN DO	WHEN TO CALL THE DOCTOR?
Feeling tired	• Try to nap, eat, and shower when your baby is napping. • Eat a healthy diet and drink plenty of fluids. • Keep taking your prenatal vitamins. • Ask family and friends for help.	• You are so tired that you can't take care of yourself or your baby. • You have a temperature higher than 101.4.
Cramps	• This is expected for seven days or longer. It may get more intense while nursing. • You can take a mild pain reliever like Ibuprofen or Naproxen.	• Severe cramping that is not resolved with pain medication.
Sore and swollen breasts (if not breastfeeding)	• Wear a firm bra that supports your breasts 24 hours a day. • Use cold packs for 1-5 days until your milk stops coming in.	• You have a sore, red, painful breast with chills, fever, and flu-like symptoms. You may have an infection called mastitis.

Your postpartum visit is very important to make sure your body is healing after delivery.

SYMPTOM	WHAT TO EXPECT AND WHAT YOU CAN DO	WHEN TO CALL THE DOCTOR?
Sore bottom, painful piles (hemorrhoids)	• Use a cold pack for the first 48 hours. • Take a sitz bath (soaking your bottom in a small plastic tub with warm water). • Use cotton balls or pads soaked in witch hazel.* • Use a spray bottle to wash your bottom several times a day. • Use over-the-counter ointments and creams like hydrocortisone.*	• You are having severe pain or are having a lot of trouble peeing or having a bowel movement.
Bleeding and discharge from your vagina	• This is normal for the first few weeks after delivery.	• You pass blood clots larger than a golf ball or have severe vaginal bleeding that gets heavier.
Soreness, numbness, or itching around your cesarean incision	• This is expected and should improve with time. • You can use the pain relievers prescribed by your doctor. • Hold your belly when you sneeze or cough. • Use pillows for extra support while feeding your baby.	• Your incision looks very red, is getting more painful, or is draining. This could be a sign of infection.

** You may be able to get these items at no cost with a prescription from your doctor.*

Ask for Help

After delivery ask for help with housework and heavy lifting. But make sure you don't spend too much time laying down. Gentle moving will help you heal more quickly. Walking reduces your risk of a blood clot in your legs.

"[The program is] above and beyond, 'cause I never seen anything like this before."

SARAH O.
Health Plan Mom

"If I were to get pregnant again, this plan and this pregnancy program would be my first choice, just because of the simple fact that they had so much to offer, and they do send out stuff like that, helpful stuff."

ANDREA J.
Health Plan Mom

In the US, it is estimated that

50%

OF PREGNANCIES ARE UNPLANNED.

— The Shriver Report

Birth Control & Family Planning

It's important to start thinking about family planning and what birth control you are going to use after you have your baby. Thinking about your goals for having or not having more children is called a reproductive life plan. It is best for the health of your future baby and you to wait at least 18 months before getting pregnant again. There are many safe forms of birth control you can use.

CREATE A REPRODUCTIVE LIFE PLAN

Ask yourself these questions:

Would I like to have more children in the future?

How many children would I like to have?

How long do I want to wait before getting pregnant again?

What birth control method do I plan to use to avoid pregnancy until I'm ready?

How can I be sure I will be able to use this birth control method without problems?

ONCE YOU HAVE ANSWERED THESE QUESTIONS, YOU NEED TO ALSO ASK YOURSELF WHAT FACTORS YOU SHOULD CONSIDER BEFORE BECOMING PREGNANT AGAIN

Is my mental and physical health as good as I want it to be?

Can I stop smoking and/or using harmful drugs?

Do I have the financial resources to support another baby?

Have I finished school?

Do I have supportive relationships to help me if I have another baby?

Now that you have thought about taking control of your reproductive life, the rest of this section will talk about safe forms of birth control that work.

Planning Ahead

There are many safe forms of birth control you can use to fit your reproductive life plan. Below is a guide to help you find the best option for you and your planning needs.

NAME	EFFECTIVENESS	PRODUCT DETAILS
SHORT-TERM CONTRACEPTION If you may want to have children within the next few years		
Birth Control Shots (Depo-Provera)	94%	Provide hormones that prevent pregnancy. You need to get the shot every 3 months. Typically stops periods temporarily. Some women gain weight from the shot.
Vaginal Ring (NuvaRing®)	91%	A flexible, plastic ring you place into your vagina. It releases hormones that prevent pregnancy. You can put it in and remove it yourself. You will not feel it during sex. You need to replace it every 4 weeks.
Birth Control Pills	91%	Provide hormones that prevent pregnancy. Easy to use and very effective when taken correctly. You have to take them every day.
LONG ACTING REVERSIBLE CONTRACEPTION (LARC) If you know you don't want to have children within the next few years		
Birth Control Implant (Nexplanon®)	99.95%	Small rod is placed under the skin of your upper arm and releases hormones that prevent pregnancy. Works for 3 years and is easily removed after 3 years. You return to your regular cycle after it is removed. There is a potential for irregular bleeding, headaches, or acne.
IUD	99.20%	T-shaped plastic device that is slid into your womb to prevent pregnancy. Good choice if you do not want to have children for several years. Sometimes this can be inserted in the hospital right after delivery. Mirena®, Skyla®, and Liletta® make your periods lighter. Paragard® has no hormones but can make your periods heavier.
PERMANENT CONTRACEPTION If you know you don't want more children and want permanent birth control		
Partner Vasectomy	99.85%	The tubes that carry sperm out of your partner's testicles are cut. Great option if you only have one partner. This can be done under local anesthesia.
*Tube Tying - Tubal Ligation**	99.50%	The tubes that carry the eggs to the womb are blocked. This procedure can sometimes be performed right after your baby is born. If you want to get your tubes tied, talk to your doctor before you deliver. In some cases, a consent form has to be signed at least 30 days before the procedure.

CONDOMS

Condoms act as a barrier to stop the spread of STIs like HIV. Because they are only 82% effective in preventing pregnancy, **condoms need to be used with another form of birth control.**

Safe Sleeping

Safe sleep is important for your baby's health. It can help protect your baby from ***sudden infant death syndrome (SIDS)***. SIDS is also known as crib death.

Risk factors for SIDS include:

- Smoking during pregnancy.
- Being premature.
- Sleeping position of the baby. Your baby should always sleep on his or her back unless your doctor tells you otherwise.
- Being around secondhand smoke.

Your First Few Weeks At Home

Everyone who goes home with a baby for the first time feels overwhelmed. It may be scary thinking about everything you need to do and know about having a new baby. Here are some great tips to help ease your worries about caring for your baby.

WHEN SHOULD YOUR BABY FIRST SEE THE DOCTOR?

It is very important to take your baby to see his or her doctor 3-5 days after birth and again before turning one month. It often helps to make your baby's doctor appointment before you leave the hospital. Babies less than one month old can get sick quickly. If your newborn looks sick, has a fever, is feeding poorly, or is sleeping too much, call your doctor right away.

WHAT SHOULD YOU DO ABOUT VISITORS?

You are going to be exhausted when you first come home from the hospital. Try to hold off on having visitors in the beginning if you can. It is OK to limit visitors or set a schedule. If you do allow visitors, make sure they wash their hands before they hold the baby. If anyone is not feeling well, ask them to come another time. Babies' immune systems are not fully developed so they get sick easily, which can be dangerous. Ask anyone who will be around your baby to get Tdap and flu vaccinations.

HOW OFTEN SHOULD YOU FEED YOUR BABY?

Babies normally feed 8-12 times per day and average 1.5-3 oz per feeding for the first week or two. Feed your baby any time he or she seems hungry. Babies may smack their lips, stick out their tongue, move their head side to side, or put their hands in their mouth as a sign that they are getting hungry. If you wait until they are crying, it is often harder to calm them down for the feeding.

HOW DO YOU KNOW YOUR BABY IS EATING ENOUGH?

Weight gain is the number one way to tell if your baby is getting enough to eat. Your baby's doctor will check their weight at every visit. It is normal for babies to lose a bit of weight at first. They will catch up within a couple of weeks. Watch your baby's diaper changes. You should be seeing at least 6 wet diapers and 3-4 poopy diapers per day.

HOW CAN YOU MAKE SURE YOUR BABY IS SAFE WHEN SLEEPING?

You should always put your baby on his or her back to sleep (unless the doctor tells you not to) in a crib or bassinet. You and your baby should never sleep in the same bed. Never place your baby on sofas, waterbeds, or other soft surfaces. Do not use soft bedding, pillows, bumper pads, or stuffed toys in your baby's sleep area. Sheets should fit tightly and only use light blankets tucked around the mattress no higher than the babies chest.

WHEN CAN YOU GIVE YOUR BABY A BATH?

Babies should only receive sponge baths until their umbilical cord has fallen off.

Glossary

There are several words that doctors and nurses use to talk about pregnancy. Knowing what these words mean will help you understand what is happening to your body.

Amniotic Fluid: This is the protective liquid contained by the amniotic sac of a pregnant female.

Anxiety: An uneasy or troubled feeling.

Birth Defect: Physical or biochemical abnormality that is present at birth and that may be inherited or the result of environmental influence.

Cervix: The lower cylinder shape part of the uterus. It connects the uterus to the vagina. During birth, it widens and flattens so the baby can pass through.

Contraceptive: Something that is used to prevent pregnancy.

Contractions: A shortening of the uterine muscles occurring at intervals before and during childbirth.

Hemorrhoid: A swollen vein on or near the anus. Hemorrhoids are also known as piles.

Induction: A procedure used to stimulate uterine contractions during pregnancy before labor begins on its own.

Jaundice: When a chemical called bilirubin builds up in the baby's blood. It causes the skin to turn yellowish in color.

Lanolin: A waxy ointment that can be used to protect skin and to treat sore nipples.

Nursing: The method of feeding the baby with milk from the mother's breast.

Ovulate: To produce or discharge eggs from an ovary.

Pitocin: A medication used to start or induce labor.

Placenta (afterbirth): A flattened circular organ in the uterus of a pregnant woman that nourishes and maintains the fetus through the umbilical cord.

Postpartum: The period of time following childbirth.

Pre-term or Premature Labor: The presence of contractions between 20 and 37 weeks.

Prenatal: Describes pregnant women and their unborn babies. Prenatal care is medical care that you receive before your baby is born.

Prenatal depression: Feelings of sadness or hopelessness during pregnancy.

Progesterone: A hormone that prepares and maintains the uterus for pregnancy.

Reproductive Life Plan: A plan regarding when or if you want to have more children. The plan should include how you will stick to your decision and what methods you will use for birth control.

Rooting: A baby's instinctive search for food that helps you recognize when your baby is hungry.

Sudden Infant Death Syndrome (SIDS): The unexplained death, usually during sleep, of a seemingly healthy baby less than a year old. SIDS is sometimes known as crib death because the infants often die in their cribs.

Sperm: A male reproductive cell.

Sexually Transmitted Infections (STIs): Infections spread from person to person through sexual contact. STIs do not always cause symptoms and may go unnoticed. STIs can be harmful to you and your baby if you are infected while pregnant. Most STIs are curable with medicine.

Tdap: One shot that protects against 3 diseases: tetanus, diphtheria, and pertussis (whooping cough). This is a shot for adults.

Uterus: The pear-shaped, hollow organ in the female reproductive system where the baby grows until birth. The uterus is also called the womb. The uterus is connected to the vagina by the cervix.

Urinary Tract Infection (UTI): When germs affect the kidneys, bladder, or the tubes connecting the organs. It can result in frequent and sometimes painful urination. It can lead to more serious health problems that can affect the baby.

Vaccine: A shot or other medicine used to prevent diseases.

Vagina: A canal shaped opening in your body also called the birth canal. The vagina connects to the cervix which is connected to the uterus.

Tracking My Pregnancy

Date I found out I was pregnant

Date I first felt the baby move

Who was the first person I told about my pregnancy?

Pregnancy symptoms

Cravings

Did I find out if you were a girl or a boy?

Baby name choices

Baby's date of birth Length Weight

Name

Last picture of me pregnant.

First picture of me and baby.

Notes

Last but not least, congratulations on your pregnancy! Soon there will be someone new in the world who thinks you are really special!

RFP 112209 O3

Attachment B.30.F
EPSDT Brochures

What is Early Periodic Screening Diagnosis Treatment (EPSDT)?

EPSDT is key to ensuring that children and young adults receive preventive, dental, mental health, developmental, and specialty services.

EARLY: Treat problems soon

PERIODIC: Set up regular appointments

SCREENING: Check for a medical problem

DIAGNOSIS: Find a medical problem

TREATMENT: Care for a problem

Why are EPSDT screenings important?

Seeing your doctor regularly and caring for problems early could:

- Help your PCP get to know your child
- Help your child stay healthy as he or she grows
- Find health problems before they get worse
- Stop health problems that make it hard for your child to learn

How do I start?

Make an appointment with your child's doctor. Contact us to get help with:

- Finding a provider
- Setting up an appointment
- Arranging transportation
- Answering your questions about screenings or vaccines
- Talking with a Care Manager to help you find and get other services

Do I need to schedule a lead screening?

Yes! Make sure you talk to the doctor about having your child tested for lead poisoning with a blood test before he or she is two years old.

You or your children may look healthy. But you can still have high levels of lead in your blood. The only way to know for sure is to have a blood test done by a healthcare provider.

Lead hurts kids:

- Sometimes you may not notice any signs of lead poisoning in children.
- Behavior, learning, and sleep problems may be caused by lead.
- Other signs: clumsiness, weakness, headaches, and hearing problems. It can also cause slow growth, stomach problems, seizures, and coma.

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Early Periodic Screening Diagnosis Treatment (EPSDT)

When and how often do I need to schedule a screening?

Getting a screening at the right time is the best way to make sure your child continues to be healthy. All EPSDT visits are covered by Nebraska Total Care.

Babies need checkups at:

BIRTH · 3-5 days · 1 month · 2 months · 4 months · 6 months · 9 months · 12 months

Toddlers need checkups at:

15 months · 18 months · 24 months · 30 months

Young children need checkups at:

3 years · 4 years · 5 years · 6 years

Young adults under 21 years of age need a checkup every year.

What happens after I see my PCP?

After the screening, the provider will help you understand the results. If you do not understand something, you can talk to our Care Managers. Here are steps that could be taken if the doctor finds a potential problem:

- For vision problems, your child could visit an eye doctor and get glasses.
- For hearing problems, your child could see a specialist and receive hearing aids.
- For problems that may require special attention, the provider will treat the issue. Or refer your child to a specialist.

Recommended Vaccines for Children from Birth Through 6 Years Old

Please consult your child's doctor about appropriate doses and any additional vaccines that may be required.

Shaded boxes indicate the vaccine can be given during shown age range. Source: www.cdc.gov.

Are vaccines safe?

Yes. Vaccines are very safe, and are important for children's health. If you have questions about vaccines, please contact us or your healthcare provider.

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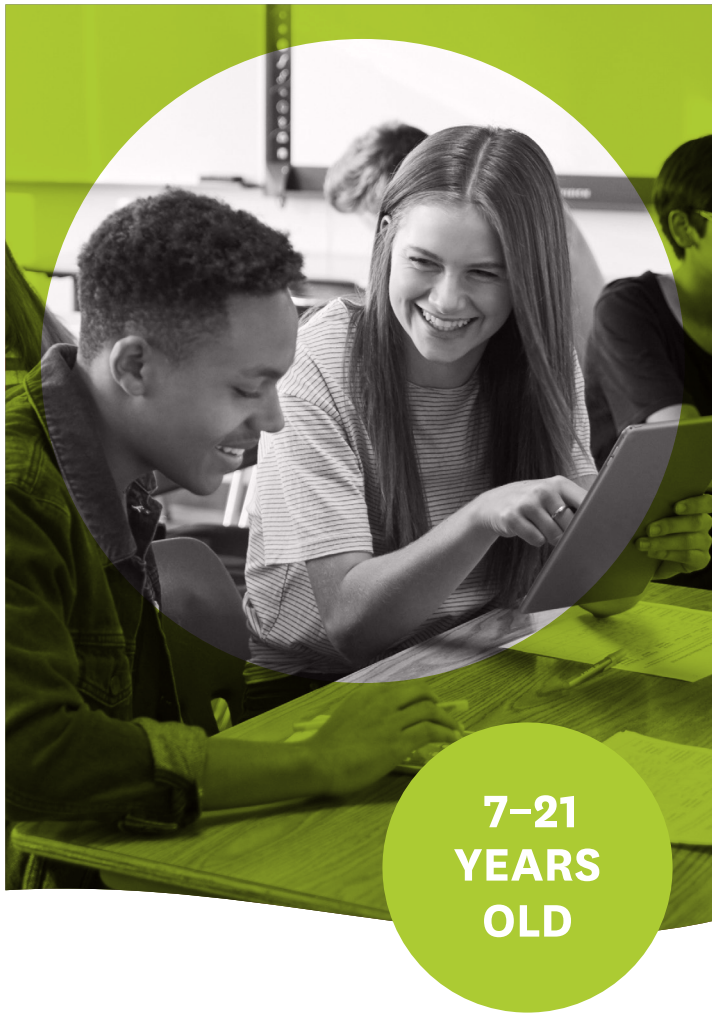

Early Periodic Screening Diagnosis Treatment (EPSDT)

When and how often do I need to schedule a screening?

Getting a screening at the right time is the best way to make sure your child continues to be healthy. All EPSDT visits are covered by Nebraska Total Care.

If your child is:

7-12 years ..... **13-18 years** ..... **19-21 years**

He or she needs a checkup every year.

These "birthday visits" are the best way to make sure your child continues to be healthy.

What happens after I see my PCP?

After the screening, the provider will help you understand the results. If you do not understand something, you can talk to our Care Managers. Here are steps that could be taken if the doctor finds a potential problem:

- For vision problems, your child could visit an eye doctor and get glasses.
- For hearing problems, your child could see a specialist and receive hearing aids.
- For problems that may require special attention, the provider will treat the issue. Or refer your child to a specialist.

Are vaccines safe?

Yes. Vaccines are very safe, and are important for children's health. If you have questions about vaccines, please contact us or your healthcare provider.

Recommended Vaccines for Children/Adults from 7 Through 21 Years Old

7-10 YEARS	11-12 YEARS	13-18 YEARS	19-21 YEARS
TDap	Tetanus, Diphtheria, Pertussis (TDap) Vaccine	TDap	TDap
	Human Papillomavirus (HPV) Vaccine (3 Doses)	HPV	HPV for Men/Women
MCV4	Meningococcal Conjugate Vaccine (MCV4) Dose 1	MCV4 Dose 1 Booster at age 16 years	
Influenza (Every Year)			
Pneumococcal Vaccine			
Hepatitis A (HepA) Vaccine Series			
Hepatitis B (HepB) Vaccine Series			
Inactivated Polio Vaccine (IPV) Series			
Measles, Mumps, Rubella (MMR) Vaccine Series			
Varicella Vaccine Series			

Please consult your child's doctor about appropriate doses and any additional vaccines that may be required.

These shaded boxes indicate when the vaccine is recommended for all children/adults unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child/adult is catching up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children/adults with certain health conditions that put them at high risk for serious diseases. Note that healthy children can get the HepA series. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

Source: www.cdc.gov.

¿Qué son los Servicios de Detección, Evaluación y Tratamiento Tempranos y Periódicos (EPSDT)?

Los Servicios de Detección, Evaluación y Tratamiento Tempranos y Periódicos son clave para asegurar que los niños y jóvenes reciban servicios preventivos y especializados dentales, de salud mental y del desarrollo.

TEMPRANOS: Tratan los problemas sin demora

PERIÓDICOS: Se hacen citas regulares

EVALUACIÓN: Se revisa para determinar si hay un problema médico

DIAGNÓSTICO: Se encuentran los problemas médicos

TRATAMIENTO: Se atienden los problemas

¿Por qué son importantes las evaluaciones de los Servicios EPSDT?

Consultar al médico con regularidad y atender los problemas sin demora puede:

- Ayudar a que su médico conozca bien a su hijo(a)
- Ayudar a su hijo(a) a mantenerse saludable a medida que va creciendo
- Encontrar problemas de salud antes de que se empeoren
- Eliminar los problemas de salud que le dificultan el aprendizaje a su hijo(a)

¿Cómo empiezo?

Haga una cita con el médico de su hijo(a). Comuníquese con nosotros para obtener ayuda para:

- Encontrar a un proveedor
- Hacer una cita
- Disponer el transporte
- Obtener respuesta a sus preguntas sobre evaluaciones o vacunas
- Hablar con un Administrador de la Atención para que le ayude a encontrar y obtener otros servicios

¿Necesito programar una prueba de detección de plomo?

¡Si! Asegúrese de hablar con el médico sobre hacerle a su hijo(a) la prueba de intoxicación por plomo con una prueba de sangre antes de que cumpla dos años de edad.

Usted y su familia pueden tener un aspecto saludable. A pesar de ello, pueden tener un alto nivel de plomo en la sangre. La única manera de saberlo con certeza es mediante un análisis de sangre.

El plomo es tóxico para los niños:

- Es posible no notar ningún síntoma de envenenamiento con plomo en los niños.
- El plomo puede causar problemas de comportamiento y aprendizaje, como también trastornos del sueño.
- Otros síntomas: torpeza, debilidad, dolor de cabeza y problemas de audición. También puede lentificar el crecimiento y crear problemas de estómago, convulsiones y coma.

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Servicios de Detección, Evaluación y Tratamiento Tempranos y Periódicos (EPSDT)

¿Cuándo y con qué frecuencia necesito programar una evaluación?

Realizar una evaluación en el momento adecuado es la mejor forma de asegurar que su hijo(a) continúe saludable. Todas las visitas EPSDT están cubiertas por Nebraska Total Care.

Es necesario realizar revisiones médicas a los bebés en las fechas siguientes:

RECIÉN NACIDOS · 3-5 días · 1 mes · 2 meses · 4 meses · 6 meses · 9 meses · 12 meses

A los niños que empiezan a caminar:

15 meses · 18 meses · 24 meses · 30 meses

A los niños pequeños:

3 años · 4 años · 5 años · 6 años

Es necesario realizar revisiones médicas a los jóvenes de menos de 21 años de edad cada año.

¿Qué sucede después de que vea a mi proveedor de atención primaria?

Después de la evaluación, el proveedor le ayudará a entender los resultados. Si hay algo que no entienda, puede hablar con nuestros Administradores de Atención. Los siguientes son pasos que podrían tomarse si el médico encuentra un posible problema:

- Para problemas de la vista, podría visitar a un médico de los ojos y obtener anteojos.
- Para problemas de la audición, podría ver a un especialista y recibir aparatos auditivos.
- Para problemas que podrían requerir atención especial, el proveedor tratará el problema. O remitirá a su hijo(a) a un especialista.

Vacunas Recomendadas para los Niños desde el Nacimiento hasta los 6 Años de Edad

Por favor consulte al médico de su hijo o hija sobre las dosis apropiadas y toda vacuna adicional que pueda ser necesaria.

Los recuadros sombreados indican que la vacuna puede aplicarse durante el rango de edades indicado. Fuente: www.cdc.gov.

¿Son seguras las vacunas?

Sí. Las vacunas son muy seguras e importantes para la salud de sus hijos. Si tiene preguntas sobre las vacunas, por favor comuníquese con nosotros o con su proveedor de atención de la salud.

¿Qué son los Servicios de Detección, Evaluación y Tratamiento Tempranos y Periódicos (EPSDT)?

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Consultar al médico con regularidad y atender los problemas sin demora puede:

- Ayudar a que su médico conozca bien a su hijo(a)
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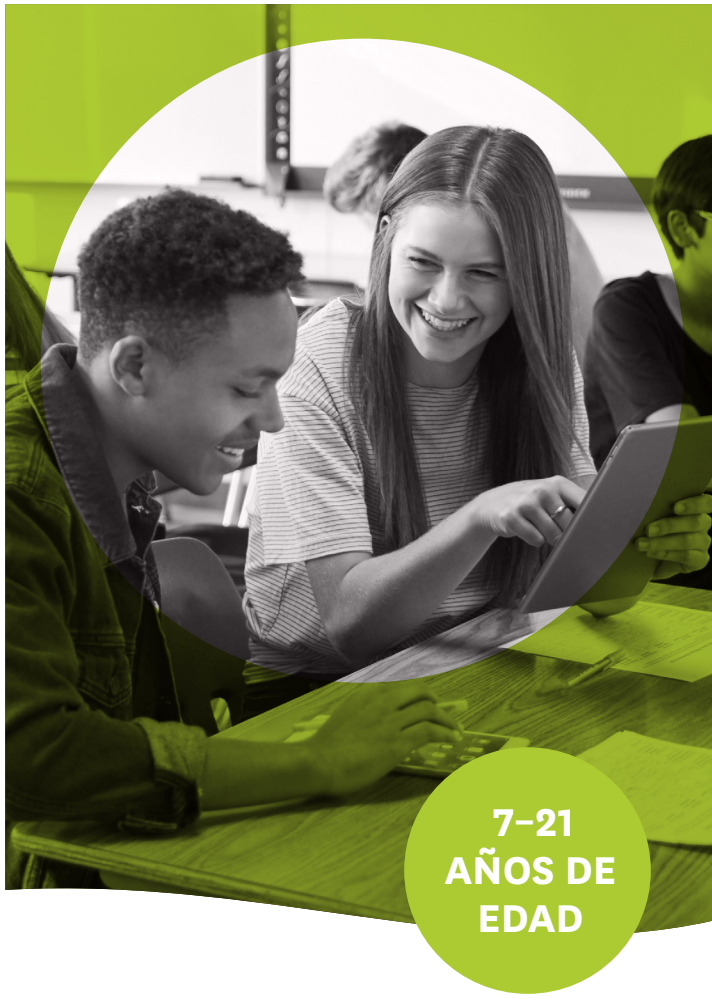

Servicios de Detección, Evaluación y Tratamiento Tempranos y Periódicos (EPSDT)

¿Cuándo y con qué frecuencia necesito programar una evaluación?

Realizar una evaluación en el momento adecuado es la mejor forma de asegurar que su hijo(a) continúe saludable. Todas las visitas EPSDT están cubiertas por Nebraska Total Care.

Si su hijo(a) tiene:

7-12 años — **13-18** años — **19-21** años

Necesita hacerse una revisión médica cada año.

Estas "visitas de cumpleaños" son la mejor forma de asegurarse que su hijo(a) continúe saludable.

¿Qué sucede después de que vea a mi proveedor de atención primaria?

Después de la evaluación, el proveedor le ayudará a entender los resultados. Si hay algo que no entienda, puede hablar con nuestros Administradores de Atención. Los siguientes son pasos que podrían tomarse si el médico encuentra un posible problema:

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¿Son seguras las vacunas?

Sí. Las vacunas son muy seguras e importantes para la salud de sus hijos. Si tiene preguntas sobre las vacunas, por favor comuníquese con nosotros o con su proveedor de atención de la salud.

Vacunas Recomendadas para Niños/Adultos desde los 7 a los 21 Años de Edad

7-10 AÑOS	11-12 AÑOS	13-18 AÑOS	19-21 AÑOS
TDap	Vacuna (TDap) Tétanos, difteria, tos ferina	TDap	TDap
	Vacuna contra el virus del papiloma humano (HPV) (3 dosis)	HPV	HPV para hombres/mujeres
MCV4	Dosis 1 de la vacuna meningocócica conjugada (MCV4)	Dosis 1 de MCV4 Refuerzo a los 16 años de edad	
Influenza (cada año)			
Vacuna Neumocócica			
Serie de Vacunas Contra la Hepatitis A (HepA)			
Serie de Vacunas Contra la Hepatitis B (HepB)			
Serie de la VacunaInactivada Contra la Poliomielitis (IPV)			
Serie de la Vacuna Contra Sarampión, Paperas, Rubeola (MMR)			
Serie de la Vacuna Contra la Varicela			

Por favor consulte al médico de su hijo o hija sobre las dosis apropiadas y toda vacuna adicional que pueda ser necesaria.

- *Estos recuadros sombreados indican cuándo se recomienda la vacuna para todos los niños/adultos a menos que su médico le indique que usted o su hijo o hija no puede aplicarse la vacuna en forma segura.*
- *Estos recuadros sombreados indican que la vacuna debe aplicarse si un niño o niña/adulto está poniéndose al día con vacunas faltantes.*
- *Estos recuadros sombreados indican que la vacuna se recomienda para niños/adultos con ciertos padecimientos de salud que les hacen correr riesgo de contraer enfermedades graves. Se hace notar que los niños saludables pueden aplicarse la serie HepA. Consulte las recomendaciones específicas para cada vacuna en www.cdc.gov/vaccines/pubs/ACIP-list.htm.*

Fuente: www.cdc.gov.

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Attachment B.30.G

Where to Go for Care Flyer

The right ***care***, the right ***place***, the right ***time***.

Free 24/7 Nurse Advice Line

Medical professionals can answer your health questions and help set up doctor visits.

Primary Care Provider (PCP)

Your PCP is your main provider. Call the office to schedule a visit if you do not need immediate medical care.

Call for:

Help caring for a sick child | Help knowing if you should see your Primary Care Provider (PCP) | Answers to health questions

Call us toll-free: 1-844-385-2192 (TTY: 711)

Where to go for **care**

Make a visit for:

Vaccinations | An annual wellness exam | Help with colds, flus and fevers | Pain | Injury | Illness | General advice about your overall health | Care for ongoing health issues like asthma or diabetes

Walk-in for:

Sprains | Stitches | Minor fractures | Nausea, vomiting or diarrhea | Rashes | Minor allergic reactions | Ear, sinus, throat, or eye pain | Urinary pain | Cold and flu symptoms | High fever (babies & toddlers may need the ER)

Go here for:

Broken bones | Bleeding that won't stop | Labor pains or other bleeding (if pregnant) | Shock symptoms (sweat, thirst, dizziness, pale skin) | Drug overdose | Ingested poison | Bad burns | Convulsions or seizures | Trouble breathing | The sudden inability to see, move or speak | Chest pains or heart attack symptoms | Gun or knife wounds

In-Network Urgent Care Center

Go to a nearby urgent care center if your illness or injury is not life-threatening and you need help quickly.

Emergency Room (ER)

Consider all of your options before going to the ER. Visit the ER if you are having a life-threatening injury or illness.

If you have any questions, visit **NebraskaTotalCare.com** or call us at 1-844-385-2192 (TTY: 711) to learn more today!

Asegúrese de saber ***dónde*** obtener ***atención*** médica cuando la ***necesite***.

Línea gratuita de consejo de enfermería que atiende 24/7

Profesionales médicos pueden responder sus preguntas sobre la salud y ayudar a programar citas con el médico.

Proveedor de atención primaria (PCP)

Su PCP es su proveedor principal. Llame al consultorio para hacer una cita si no necesita atención médica inmediata.

Llame para recibir:

Ayuda para cuidar a un niño enfermo | Ayuda para saber si debe consultar con su Proveedor de atención primaria (PCP) | Respuestas a preguntas sobre la salud

Llámenos sin costo: 1-844-385-2192 (TTY: 711)

Dónde acudir para recibir **atención médica**

Haga una cita para:

Vacunas | Un examen anual de bienestar | Ayuda para tratar resfriados, gripes y fiebres | Dolor | Lesión | Enfermedad | Consejos generales sobre su salud en general | Atención para problemas de salud continuos como el asma o la diabetes

Entrar por:

Esguinces | Puntadas | Fracturas menores | Náuseas, vómitos o diarrea | Dermatitis | Reacciones alérgicas menores | Dolor de oídos, sinusitis, garganta o ojos | Dolor urinario | Síntomas de resfriado y gripe | Fiebre alta (Las bebés y los niños pequeños pueden necesitar la sala de emergencias)

Acuda aquí si tiene:

Huesos fracturados | Sangrado que no para | Dolores de parto u otros sangrados (si está embarazada) | Síntomas de shock (sudoración, sed, mareos, piel pálida) | Sobredosis de medicamentos | Ingestión de veneno | Quemaduras graves | Convulsiones o ataques | Problemas para respirar | Incapacidad repentina para ver, moverse o hablar | Dolores en el pecho o síntomas de infarto de miocardio | Heridas por arma de fuego o arma blanca

Centro de atención urgente dentro de la red

Acuda a un centro de atención urgente de su localidad si su enfermedad o lesión no pone en peligro su vida y necesita ayuda rápidamente.

Sala de emergencia (ER)

Considere todas sus opciones antes de acudir a la sala de emergencia. Acuda a la sala de emergencia si tiene una enfermedad o lesión que pone en peligro su vida.

Si tiene alguna pregunta, visite **NebraskaTotalCare.com** o ¡llámenos hoy al 1-844-385-2192 (TTY: 711) para obtener más información!

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B. Technical Approach

V.H Grievances and Appeals

V.H Grievances and Appeals

31. Provide a flowchart and comprehensive written description of the Bidder's member grievance and appeals process, including the approach for meeting the general requirements and plan to:

• Ensure individuals who make decisions about grievances and appeals have the appropriate expertise and were not involved in any previous level of review.

• Ensure an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how the Bidder will determine when the expedited process is necessary.

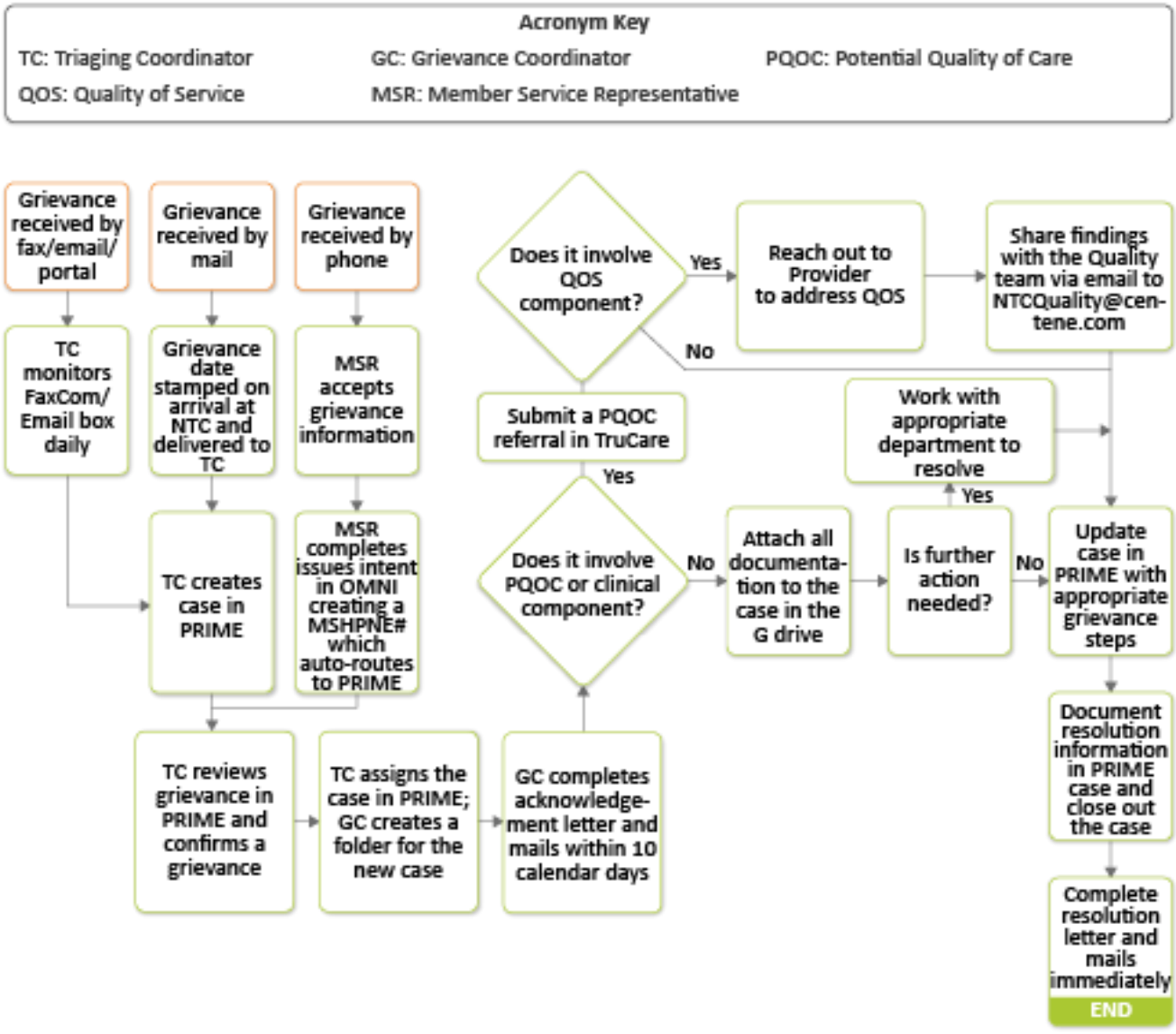
• Use data from the grievance and appeals system to improve the Bidder's operational performance.

Page Limit: 3 (Per Addendum 1, Q&A #112 flowchart is not included in the page limit)

Grievances and Appeals Process

Nebraska Total Care has a well-established Grievance and Appeals System that meets all MLTC requirements. The grievance system encompasses the grievance process, the appeal process, and access to the State's fair hearing system. Our processes for identification, receipt, tracking, response, review, reporting, and resolution of Heritage Health member inquiries, grievances, and appeals comply with all State, Federal, and NCQA requirements. We maintain written policies and procedures clearly describing the member grievance and appeals process and make these policies and procedures available to providers and members. These policies and procedures govern the resolution of inquiries, grievances, and appeals, and encompass internal review, expedited review, external review, and access to the State's fair hearing system. Please see **Figure B.31 Member Grievance Flow Chart**.

Figure B.31 Member Grievances Flow Chart



Authority and Staffing. Our Board of Directors has final authority and responsibility for the grievance system process, and delegates operational oversight and implementation to our Quality Assessment and Performance Improvement Committee (QAPIC). The QAPIC reviews all inquiries, appeals, complaints, and grievance summaries quarterly to identify issues requiring follow-up or improvement. This review includes all inquiries, appeals, and complaints resolved by Subcontractors under a delegated agreement. Our Performance Improvement Team performs a monthly in-depth review of complaints, grievances, and appeal data to identify trends and root causes of dissatisfaction. Root cause trending informs proactive interventions to reduce member grievances. For example, we worked with our NEMT partner on incentive-based contracting to reduce grievances for transportation services. We also created provider education that is included on our website and distributed to providers and stakeholders to support a reduction in member-balanced billing complaints.

Our Grievance System Manager (GSM) is responsible for ensuring we document, route, process, track, resolve, and report all aspects of the process, per MLTC requirements. In addition, we train all Nebraska Total Care staff about the importance of the grievance process, member and provider rights, and how to assist members and providers with grievances. Six Nebraska-dedicated G&A Coordinators with a combined 21 years of experience support our GSM. They are cross-trained in appeals, grievances, and State fair hearings.

Receipt and Documentation. Members, authorized representatives acting on a member's behalf, and providers (with a member's written consent) may file a grievance orally, electronically via the Member Portal, in person, or writing. Providers can enter grievances online via the secure Provider Portal to assist members with the grievance process. Member Service Representatives (MSRs) document the substance of the grievance, complete a task in our Customer Relationship Management platform (CRM) and assign it to the grievance CRM queue for timely processing.

Acknowledgment. Staff receiving a member's oral grievance acknowledge the grievance and attempt to resolve it immediately. We forward all oral or written grievances to the GSM for tracking, written acknowledgment, and resolution. Per Section H, the GSM acknowledges submitted grievances within 10 calendar days of receipt. The GSM includes a description of the grievance procedure in the acknowledgment letter, including the timeframe for resolution. To ensure we meet all timelines, our team receives daily aging reports generated from our G&A system, an integrated component of our CRM platform.

Investigation. The GSM conducts an initial investigative review. This may include contacting the member (or the member's authorized representative) for additional information or clarification of the issue and gathering applicable documentation from other Nebraska Total Care departments. If the grievance involves a quality-of-care issue, the GSM escalates it to the QI Department for review and resolution as a part of the quality of care investigation process. The GSM forwards matters involving privacy concerns or potential fraud and abuse to the Nebraska Total Care Compliance Officer.

Notice of Decision. Our GSM renders a decision regarding the grievance as expeditiously as possible, not to exceed 90 calendar days of receipt. The GSM sends written notice of the decision and disposition of the grievance within 90 calendar days of the receipt of the grievance. Regardless of the outcome, Nebraska Total Care does not discriminate or retaliate against a member for filing a grievance.

Appeal of Adverse Action. An appeal is defined as a request for review of an action taken by a health plan. Members have up to 60 calendar days from the date of adverse action to file an appeal. Members, authorized representatives with written consent from the member, and the legal representative of a deceased member's estate may file an appeal orally or in writing. We consider all verbal inquiries related to seeking to appeal an action, as an appeal.

Timely, Responsive Notification

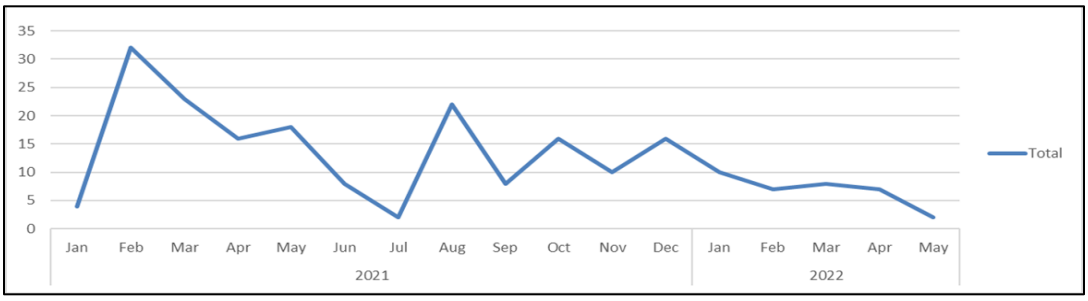
Nebraska Total Care has consistently exceeded the required grievance resolution and completion times, sending written notification of the grievance resolution within 35 days.

Acknowledgment. A Clinical Appeals Coordinator (CAC) documents appeals requests within one business day of receipt. The CAC sends an acknowledgment letter that includes the subject of the appeal, an explanation of the appeal process, and the member's rights, including the right to submit comments, documents, or other evidence and allegations of fact or law relevant to the appeal in person or writing. We encourage members to submit documentation to support their case, and we remind them of the limited time available for expedited appeals. The CAC provides the member or their representative access to and copies of the member's file at no cost.

Resolution Time Frame. Nebraska Total Care resolves appeals as quickly as the member's health condition requires. In the case of standard appeals, appeals are resolved, and the member and provider are notified within 30 calendar days of receipt, and for expedited appeals, within 72 hours of receipt. ***Appeals are resolved in an average of six days.*** The resolution time frame may be extended for up to 14 calendar days if the member requests the extension, or if the delay is

in the member's best interest and the member agrees to the extension. We provide members with written notification within two calendar days on the reason for the delay for extensions not requested by the member, and information on filing a grievance if the member disagrees with the determination. We are proud to share the positive results of our initiative to reduce grievances for NEMT Complicated Trips in **Figure 31.A**. Our Complicated Trips Committee meets monthly and was formed to support grievance reduction of NEMT complaints based on root cause analysis.

Figure 31.A Population Complaint Trend by Appointment Data



Levels of Review. A physician with appropriate clinical expertise reviews appeals involving clinical issues or any medical necessity decisions. The individual is in the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination and who was not involved in the initial determination or any prior decision-making.

Timing of the Notice of Standard Appeal Resolution. The CAC provides written notice of standard appeal resolution to the member and the provider within 30 calendar days following receipt of the appeal. Appeal resolution notices include resolution results and the date it was completed. For appeals not resolved wholly in favor of the member, our adverse appeal resolution notices include the decision and date of resolution, the right to request a State fair hearing, how to request a hearing, and the right to continue to receive benefits pending a hearing, and how to request continuation of benefits. The notice informs the member that they may be liable to pay for continued benefits received while the appeal was pending if our decision is upheld.

Access to State Fair Hearings. Nebraska Total Care members have the right to request a State fair hearing if they are not satisfied with the final decision after exhausting the Nebraska Total Care Grievance and Appeals procedure, within 120 calendar days from the date of the Notice of Action. A provider may request a State fair hearing on behalf of a member with the member's prior consent. We notify members of their right to request a State fair hearing, how to obtain a hearing, and representation rules at a hearing using a variety of education to ensure members are given access to the State fair hearing process. Our GSM monitors all State fair hearing requests, and our Medical Director represents Nebraska Total Care at all State fair hearings.

Continuation of Benefits. We will continue a member's benefits through the appeal resolution process if the appeal was filed within 10 calendar days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the period covered by the original authorization has not expired; the member requests an extension of benefits. If these conditions are met, benefits are continued throughout the appeal process. The services remain in place until at least one of the following occurs: the member withdraws the appeal, 10 calendar days pass after Nebraska Total Care mails the notice of an adverse action, a State fair hearing decision adverse to the member is made, or the authorization expires, or limits are met.

Ensuring Individuals who Make Grievances and Appeals Decisions have the Appropriate Expertise

Appropriate Expertise. We train all MSRs and Care Management staff to document and resolve member concerns during the first contact, whenever possible. All member-facing staff is trained to recognize any expression of dissatisfaction and follow procedures to resolve member issues. Our written policies ensure that no punitive action will be taken against a provider who supports a member's complaint, grievance, or appeal, or who files a complaint, grievance, or appeal on a member's behalf. We ensure the Nebraska Total Care staff or Medical Director (PH, BH, Dental) involved in the resolution of grievances or appeals were not involved in any prior level of review or decision-making. Physicians involved in reviewing any grievance or appeal involving clinical issues, an appeal of a denial based on lack of medical necessity, or a grievance regarding denial of expedited resolution of an appeal, have appropriate experience treating the member's condition or disease (same or similar specialty) and have not been involved in any prior level of review or decision-making. We expedite this process when taking the standard time could seriously jeopardize the member's health. As part of this process, we use established criteria to determine when the expedited process is necessary.

Expedited Appeal Process. We follow MLTC's timeframes and processes for handling expedited appeals, including

extending periods within guidelines. A member or provider may request an expedited appeal if following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Criteria for Expedited Appeals. The CAC immediately gathers documentation for expedited appeal requests and sends it to an MD (a physician with the same or similar specialty, who was not involved in any previous level of review). Before issuing a final adverse determination, the Medical Director contacts the requesting provider to obtain any additional information the provider or member would like them to consider. Requests related to an ongoing admission, continued hospitalization, or other health care services for a member who has received emergency services but has not been discharged are processed as an expedited appeal request.

Resolution Process and Timeframes. For expedited appeal requests, our Medical Director renders a decision within 72 hours of receiving the request or sooner, as a member's condition requires. The resolution timeframe is extended for up to 14 calendar days if the member requests an extension, or if the delay is in the best interest of a member and the member agrees to the extension. If our Medical Director denies a request for an expedited appeal resolution, we transfer it to the standard resolution process with a resolution timeframe no longer than 30 calendar days from the day we receive the appeal with a possible extension of 14 calendar days. We provide the member with prompt verbal notice of the denial and written notice within two calendar days.

Using Data from the Grievance and Appeals System to Improve Operational Performance

We perform monthly in-depth reviews of grievance and appeals data to identify trends, root causes, and issues requiring follow-up. We assess whether Nebraska Total Care and MLTC standards for timeliness and processing are met; identify patterns related to specific issues, providers, or departments; and take actions, as highlighted in **Table 31.B**. The Utilization Management Committee reviews appeals data to identify trends that indicate when specific utilization guidelines should be updated, developed, or clarified; or when provider education is needed. We submit grievance and appeals and processing standards data quarterly to the QAPIC for trending and analysis. We incorporate aggregate data for the member and provider experience analysis for the annual QI Program Evaluation.

Table 31.B Using Grievance and Appeal Data to Improve Operational Performance

Performance Issue	How Data Will be Used	Department
Access/Availability Deficiencies	Identify network gaps to enable contracting outreach; education to meet identified timeliness standards	Provider Relations and Network Contracting
Quality of Care (QOC), Member Safety, Abuse	Provider training related to appropriate clinical practice guidelines and practices, recredentialing review	Medical Director, QI
Benefit Questions	Improvements to member written materials	Member/Provider Services, Marketing
Service Levels	Staffing adjustments and training/re-education	Member/Provider Services
Inappropriate Billing Practices	Business process improvement and provider education, regulatory billing guidance	Compliance/Special Investigations

32. Describe the approach the Bidder will take to provide members with grievance, appeal, and State Fair Hearing information. Address how the Bidder will ensure the grievance and appeals system policies and procedures, and all notices, will be available in the member's primary language and that reasonable assistance will be given to members to file a grievance or appeal. ***Page Limit: 2***

Member Assistance Related to Grievances and Appeals

Member Notification of Grievance, Appeal, and State Fair Hearing Information and Rights. Nebraska Total Care uses multiple methods to educate and notify members about their rights to file grievances and how to submit appeals or request a State fair hearing. We educate members about the Member Grievances and Appeals Policy through our Member Handbook, Member Newsletters, public website, during telephonic and face-to-face member interactions, and via member enrollment materials. The information includes:

- A member's right to file grievances and appeals
- Requirements and timeframes for filing a grievance or appeal
- Availability of Nebraska Total Care assistance in the filing process
- Toll-free numbers that a member may use to file a grievance or appeal by phone
- The fact that, if requested by a member and under certain circumstances:
  - Benefits will continue if a member files an appeal or requests a State fair hearing or external review within specified timeframes
  - The member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member
  - For a State fair hearing
    - The right to a State fair hearing
    - The method for obtaining a hearing
    - The rules that govern representation at the hearing

All information is provided in plain language and at a 6th-grade reading level.

We are enhancing our grievance submission process to enable members to submit grievances via our secure Member Portal. In our member materials and on our website, we will inform members where they can locate the electronic form and how to submit a grievance.

Availability of Grievances and Appeals Materials in Alternative Languages and Formats

Our Member Services Representatives (MSRs) offer personal assistance to any member needing support in any stage of the grievance filing or appeal filing process, including communication assistance such as translation, TTY/TDD availability, interpreter services, or alternative formats for materials. We make forms available to members, providers, and other authorized representatives to submit grievances or appeals on behalf of members.

We provide appeal forms for all written adverse action notices on our website, Member Portal, Provider Portal, and upon request. We direct member eligibility and eligibility-related grievances and appeals including termination of eligibility, effective dates of coverage, and other related issues to MLTC.

Member Grievance and Appeal Filing Assistance

Members should have their concerns and issues heard and addressed as soon as possible. We educate members about how to contact our Member Services department if they have an inquiry or concern, and about the grievance process, via the Member Handbook, on our website, Member Portal, and at least annually in our Member Newsletters. We write all materials in easy-to-understand language and at MLTC's required 6th-grade reading level.

A member or member's authorized representative may contact Nebraska Total Care at any time with an inquiry on behalf of a member. They may contact us orally, in writing, by mail, facsimile, email, through the Member Portal, or by dialing our toll-free member services center, or in person. We take pride in our responsive member service and attempt to resolve an issue or inquiry for the caller at the time of the call.

We train all Nebraska Total Care staff to identify, document, and when appropriate, route verbal or written issues, inquiries, grievances, or appeals to the Grievance System Manager (GSM) or the Clinical Appeals Coordinator (CAC). We have learned from experience that most individuals and members call the member services center with their initial inquiry. When responding to inquiries, MSRs use our CRM platform to assist members in addressing issues or provide information to the member's satisfaction. Staff is trained to support dual-eligible members, including HIDE SNP members, in navigating Medicaid and HIDE SNP appeals and grievance submissions. We support timely resolution for all grievances, appeals, or Compliant Tracking Module (CTM) issued by CMS.

We ensure that communication with designated representatives on behalf of members is HIPAA compliant. Our GSM confirms that the member has provided written consent for any representative contacting us on the member's behalf. When appropriate, the GSM supplies a consent form for the member to complete and return. The Utilization Management Committee reviews appeals data to identify trends that indicate when specific utilization guidelines should be updated, developed, or clarified; or when provider education is needed. In all cases, the member has access to Nebraska Total Care assistance in filing member inquiries, grievances, appeals, or requests for State fair hearings.

Our Grievance and Appeals Coordinators assist members with issues that require a higher level of support than the member services center provides. If a member calls in with an issue that an MSR feels would be best addressed by a Grievance and Appeals Coordinator, the MSR warm transfers the member's call to a Grievance and Appeals Coordinator. In addition to providing other forms of assistance, a Grievance and Appeals Coordinator can help a member with the grievances or appeals filing process and can provide education about the State's fair hearing process. Nebraska Total Care refers members, as appropriate, to the Nebraska Long Term Care Ombudsman Program, Disability Rights Nebraska, and other community resources that can assist members as they determine whether to file a grievance or appeal.

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B. Technical Approach

V.I Provider Network Requirements

V.I Provider Network Requirements

33. Describe the Bidder's proposed provider network outreach approach and recruitment strategy. Provide a detailed work plan for developing an adequate network within the timeframe described in Section V.I. Describe the method the Bidder plans to use on an ongoing basis to assess and ensure that MLTC's network standards are maintained, including standards related to:

- *Distance.*
- *Appointment access.*
- *Cultural competency.*
- *After-hours access.*
- *Inclusion of PCPs.*
- *Inclusion of dentists and dental specialists.*
- *Inclusion of behavioral health providers.*
- *Inclusion of high-volume specialists.*
- *Inclusion of FQHCs and RHCs.*
- *Inclusion of urgent care centers.*
- *Inclusion of pharmacies.*
- *Inclusion of hospitals.*
- *Inclusion of Non-emergency transportation*

Page Limit: 6 Excluding plan for developing an adequate network

Approach to Developing and Managing a Qualified Network

Nebraska Total Care has provided Heritage Health members access to an established, comprehensive provider network since 2017. Our network of over 28,700 providers exceeds the Scope of Work requirements for network adequacy in urban, rural and frontier counties, ***achieving 100% access standards statewide for providers (see Table 33.A),*** except in those counties that do not have hospitals. This includes our transportation network which provides coverage across the State of Nebraska, with 99.4% of requested trips completed successfully.

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. 85% of the State (79 out of 93 counties) is considered rural or frontier, with 41 identified as provider shortage areas. Approximately 21% of members enrolled in Nebraska Total Care live in a rural or frontier community. We bring a collective focus to issues facing rural and frontier communities across the State and work collectively to design and implement innovative programs that improve the health of the community, one person at a time.

Facilitating Access to the Right Care in the Right Place

Nebraska Total Care is contracted with:

- **100% of Nebraska FQHCs**
- **100% of Nebraska Critical Access Hospitals**, including Rural Health Clinics
- **90% of urgent care locations**

We build strong relationships with high-performing providers to support high quality care and equitable access to services. We implement strategies to ensure access to care for all members, such as through ***PROJECT ACCESS*** (described in detail below), telehealth solutions, and out-of-network (OON) providers in State or neighboring States. ***NCQA's 2021 Published Medicaid Health Plan Ratings identified Nebraska Total Care as the only Medicaid Health Plan in Nebraska with a 5-Star Patient Experience rating.***

Table 33.A Highlights of our comprehensive provider network that meets time and distance standards.

Provider Type	Provider Location Count	Provider Member Ratios	% Contracted (from State File)	Meets Adequacy Standards
PCP	12,622	1:31	97%	☑
OB/GYN	1,596	1:99 (females >12 years of age)	99%	☑
General Surgery	765	1:161	90%	☑
Orthopedics	1,562	1:298	97%	☑
Neurology	765	1:322	96%	☑

Provider Type	Provider Location Count	Provider Member Ratios	% Contracted (from State File)	Meets Adequacy Standards
Cardiology	361	1:1,093	99%	☑
Hospitals	193	1:694	100%	☑
Psychiatry	361	1:213	93%	☑
Pharmacy	825	1:150	90%	☑
All other BH	1987	1:33	96%	☑

Network Development Methodology and Recruitment Strategy

As an incumbent MCO with five years of local network development experience, we focus on recruiting and retaining providers that provide the most efficient, culturally competent, and highest quality care to members. When determining our network development strategies, we consider multiple factors such as population characteristics, demographics, patterns of care, SDOH needs/barriers, and provider capacity (e.g., ratios, appointment availability, panel status, willingness to accept Medicaid members, and urgency of the need for services).

Nebraska Total Care goes beyond traditional time and distance standards to recruit the right types of providers to ensure equitable access to culturally responsive and linguistically appropriate services. We build and maintain a network that offers timely access to all services for all members, including those with limited English proficiency or physical or intellectual/developmental disabilities. Our approach includes:

- **An Experienced, Local Approach Built on Trust.** Throughout our tenure serving Heritage Health members, Nebraska Total Care's high-touch, locally based Contracting and Network Development team continually engages with Nebraska communities to identify needs and add high-quality providers to our network. For example, our Tribal partners contacted our Tribal Liaison and requested that we expand our network in South Dakota. In response to this request, our Contracting and Network Development team completed agreements with both Avera Health and Sanford Health Systems to enhance our network for those residing in Northeast Nebraska. This was impactful for Tribal members residing within the Santee Sioux Nation, Omaha Tribe of Nebraska, and Winnebago Tribe of Nebraska reservations and the service delivery area of the Ponca Tribe of Nebraska. ***Our expanded network addressed health disparities for geographically vulnerable Tribal members by providing increased access to hospital and specialty care.***
- **A High-Touch, Responsive Provider Engagement Model.** Developing and maintaining positive provider relationships is central to our provider recruitment strategy. if we identify a provider not currently in the network, we promptly reach out to educate them about Nebraska Total Care and begin efforts to execute a contract. Our high-touch support includes assigning a ***local, single point of contact*** to each provider group. Our team of Provider Relations Representative conduct regular outreach, initial orientation, training, program promotion, and prompt issue resolution. Much of what attracts providers to Nebraska Total Care is what makes them stay, evidenced by a ***less than 1% voluntary contract termination rate*** year-over-year since our inception. We retain and support providers in delivering high-quality, accessible care through our Provider Engagement model, VBP, training, ongoing provider investment, and efforts to reduce provider administrative burden. This includes administrative self-service capabilities through our secure ***Provider Portal***, such as online grievance submission; eligibility inquiries; and prior authorization requests and status.

"Cheryl is an outstanding representative for Nebraska Total Care. She is always available when we have questions and gets back to us in a timely manner so we can get any issues resolved. Cheryl has billing experience that has been a valuable tool when she helps us resolve billing concerns. I can say without hesitation, that she is our best Heritage Health plan representative and the best one we have ever had. I feel confident in the information she gives us, and I know I can count on her to help us when we need it."

- Carla Meng, Director, Box Butte General Hospital

- **Monitoring to Inform Network Expansion.** We continually assess the adequacy of our provider network to inform our recruitment efforts, enabling us to expand the network to serve additional populations such as the Heritage Health

Adult expansion population. Our assessment includes Primary Care Providers (PCPs), high-volume specialists, Behavioral Health (BH), and other specialist types identified by MLTC, and facilities such as hospitals, FQHCs, RHCs, and Urgent Care Centers. We analyze GeoAccess reports, by county and zip code, to evaluate our network based on time and distance standards. We apply a Provider Capacity Stress Test analysis based on a statewide member to provider type ratios and NCQA standards. We proactively outreach providers on the Nebraska Medicaid Provider file and Nebraska license files that were not already in Nebraska Total Care's network, which resulted in ***over 250 additional contracts, which yielded 15 new out of state hospitals and over 1,400 new practitioners in our network.***

- **Building Meaningful Relationships with Key Stakeholders**. Guided by our physician-led Board of Directors, with health leaders from across the State, we have established strong working relationships with Nebraska providers and associations. Nebraska Total Care staff regularly receives network adequacy input from local stakeholders such as members, families, State and local medical and provider associations; primary care, BH, and specialty care providers; and community organizations. Each of our Medical Directors maintains an active practice and cares for members alongside external providers, gaining a better understanding of the challenges many providers face. Our staff facilitate Joint Operating Committee (JOC) meetings with hospital systems and other large provider groups to discuss potential adequacy and access issues as a routine part of the agenda. These stakeholders are critical to helping us understand local communities, member characteristics and patterns of care, and SDOH barriers.

"We have been very pleased to work with Nebraska Total Care for the last several years. Not only are they advocates for their members, but they are also great advocates for the providers. 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 Harlow, Chief Revenue Officer and Executive Director of Foundation, Fillmore County Hospital

Detailed Work Plan for Maintaining and Expanding Nebraska Total Care's Adequate Network

As an incumbent, Nebraska Total Care has a comprehensive, statewide network that meets adequacy and access requirements. ***We contract with every health system in the State, including all FQHCs, Critical Access Hospitals, and Rural Health Clinics.*** Additionally, through Envolve Dental, we offer an expansive network of dental providers that is ready to serve Heritage Health members. **Attachment B.33 Network Development Plan** includes our detailed work plan for maintaining and expanding our provider network (including dental) as prescribed in Section I.18, Provider Network Requirements of the RFP. We are fully prepared to submit to MLTC a provider enrollment file that demonstrates network adequacy within a minimum of 120 calendar days prior to the Contract Start Date.

As detailed in our Network Development Plan, we have strategies in place to develop a comprehensive dental network that builds on our existing network to offer timely access to dental care for Heritage Health members. Our Dental Management Coordinator, Dr. Jon Rich, and our new Nebraska-based Dental Director and will oversee our relationship with Envolve Dental and our overall dental health strategy. We currently manage a comprehensive dental network for our HIDE SNP membership, which we will leverage to serve Heritage Health members. Our dental network is:

- Developed to meet network adequacy standards
- Experienced in serving the Medicaid population
- Culturally responsive and reflective of the population served
- Well-equipped to serve members with special health care needs, including Endodontists, Oral Surgeons, Orthodontists, Pedodontists, Periodontists, and Prosthodontists

Established Dental Network

Our current Nebraska Medicare dental network includes:

- 431 dental providers

Additional expansion efforts for Medicaid have already resulted in:

- 35 signed Letters of Intent
- 24 verbal commitments from dental practices that will become part of our Heritage Health dental network
- 246 additional recruitment outreaches

Envolve Dental continues to outreach dental providers to maintain a strong dental provider network and establish solid partnerships with providers. We manage an "any willing provider" network that includes FQHCs, RHCs, and large dental service organizations, along with private practice dentists. Our network development strategy begins with stakeholder engagement and an understanding of the local community. Our network team meets with the Nebraska Dental Association, Health Center Association of Nebraska, and other thought leaders to remain relevant in the community and informed of its needs.

Their input and stakeholder feedback informs our network development strategy.

Assessing and Maintaining Network Adequacy Standards

Nebraska Total Care's written policies and procedures (P&Ps) outline staff accountability, along with our processes and systems for maintaining a comprehensive network that meets MLTC's standards for time, distance, appointment access, cultural competency, after hours access, and the inclusion of providers and facilities to deliver all Covered Services. Our Network Development team audits against network P&Ps and deploys prospective network analytics and GeoMapping aligned to Heritage Health requirements for ongoing monitoring. We supplement our data with local insights and the provider landscape, gleaned from our staff's daily work with providers across Nebraska.

Nebraska Total Care's Contracting and Network Development team is constantly looking for opportunities to improve our network and expand access to care. The team reports annually to our Quality Assessment and Performance Improvement Committee and Health Equity and Diversity Committee through an NCQA-driven Annual Integrated Availability Report. We conduct routine monitoring to confirm our network of PCPs, dentists and dental specialists, behavioral health providers, high-volume specialists, FQHCs and RHCs, urgent care centers, pharmacies, hospitals, and non-emergency transportation. As shown in **Table 33.B,** we regularly monitor to ensure our network meets and exceeds adequacy standards for distance, appointment access, cultural competency, and after-hours access.

Table 33.B Processes to monitor time, distance, appointment, access and after hours standards and inform actions.

Network Standard	Data Source	Frequency	How Data Helps Identify Gaps/Access Issues
Distance	County-level GeoAccess mapping, provider-to-member ratios, and panel status reports	Quarterly	Confirms the availability of providers considering distance/travel time from members' residences and identifies potential capacity issues.
Appointment Access, After Hours	Appointment Availability Audits	Quarterly	Proactively identifies potential capacity and access issues, and provider compliance with network standards. Confirms adequate access to after-hours/weekend care.
Appointment Access, Cultural Competence, After Hours	Complaints, Grievances, Appeals	Quarterly	Identifies member complaint trends related to accessibility, and appointment availability through our Access to Care Subcommittee.
Cultural Competence	Population Health, SDOH, and Cultural Competency Needs Assessments	Continuous and Ongoing	Overlays network with member characteristics/needs to identify gaps/access issues based on disease prevalence, SDOH barriers, and geographic, racial, ethnic, linguistic, or other disparities. Identifies providers with capacity to address member needs.
Distance, Access	Current/Anticipated Enrollment and Utilization by Zip Code	Quarterly	Analyzes member demographics and health care needs, and network capacity or gaps based on these needs.
Distance/ Appointment Access	Out-Of-Network Utilization, Transportation Reports	Weekly	Identifies potential availability issues by region/provider type, member patterns of care trends, contracting/workforce development opportunities.
Appointment Access, Cultural Competence, After Hours	CAHPS and Provider Satisfaction Surveys	Annual	Identifies issues related to access and appointment availability through our Provider Advisory Committee.

Nebraska Total Care maintains a Zero Gap policy for our network to make sure members do not face any issues accessing care regardless of where they reside. As part of this policy, our reporting process proactively identifies areas where we minimally meet compliance standards, signifying an area of vulnerability. Our Network Contracting team targets these areas and recruits new providers to bolster provider availability and exceed access standards. Even though we exceed accessibility standards, we continually assess our network to proactively identify potential gaps before they occur and actions to encourage providers to participate in our network and increase access to services.

Value-based Purchasing (VBP). We offer VBP models that incentivize providers to stay in the network and improve access

and outcomes. For 2021, we estimate that our providers will earn over $4.9 million in value-based payments. Providers often use these payments to reinvest in their practices, expanding access, service capacity, and improving quality. We have established VBP partnerships with key health systems including Catholic Health Initiatives, Nebraska Medicine, Nebraska Methodist, OneWorld, Bluestem, Bryan Health, and Great Plains Health. We are investing in and engaging providers by adding Equity-Based Contracting as a new dimension to our QualityPATH VBP programs. QualityPATH includes provider incentives for reducing health equities for members they serve and submitting Z codes that provide administrative data in support of the identification of SDOH needs that inform our health equity strategies.

Out-of-Network and Out-of-State Providers. If a member's care cannot be provided in-network, we arrange for them to receive services from a qualified provider located within the State, preferably within the member's community. For situations where an out-of-network or out-of-state provider is the only service provider available, we develop Single Case Agreements (SCAs). Our SCAs solidify payment terms, authorization parameters, and treatment plans to ensure thorough Care Coordination and appropriate transition to in-network services as appropriate.

In situations where we have confirmed that there are no providers available within a specific county or region, we identify member patterns of care using claims and utilization data and by speaking with the local provider community to understand referral patterns for specialty services. For example, we have relationships with out-of-State providers in border States, such as Cheyenne Regional Medical Center of Wyoming; HCA Healthcare, including Presbyterian St. Luke's and Swedish in Colorado; St. Luke's, Mercy, and others in Iowa; and Avera, Sanford, and Monument Health Systems in South Dakota. These regional hospitals offer access to a breadth of specialties and services that may not be available in the member's community. This occurs mainly in a tertiary care setting or when the member has a rare illness or diagnosis that is best treated at a Center of Excellence, some of which are located out of State. In these situations, our Care Coordination teams are at the forefront of the process (communicating with providers, scheduling appointments, arranging transportation and lodging) until the member's health care issue is resolved and they return home for follow-up care with in-State providers.

Short Term Plan for Addressing Capacity. If we identify a gap or access issue within our network, we respond quickly to secure services. We outreach to network providers to open PCP panels, expand the scope of services, use physician extenders, recruit providers in other lines of business to serve Heritage Health Members or facilitate SCAs, and provide ADA-compliant transport to nearby providers, and/or offer telehealth. We facilitate access to OON providers and flexible alternatives for providers in short supply. Written policies and procedures allow for referral and payment to OON providers based on prior authorization.

If an OON provider is willing to accept Heritage Health rates, no SCA is required, and the authorization serves as notification and approval for payment. Providers and members are notified of our process to access OON providers via the Provider Handbook and Member Handbook. We train provider- and member-facing staff on OON policies and procedures. Providers may call Provider Services for assistance finding an in-network specialist or an OON alternative.

Expanding Access – Envolve Vision Van

To respond to flood victims who may have needed replacement glasses, Nebraska Total Care brought the Envolve Vision, Inc. (Envolve Vision) van to Fremont and Bellevue. Over two days, the Envolve Vision van did over 178 vision screenings and, for 68 of those, another exam was necessary. The members met with a doctor and were provided prescription glasses. This resulted in us providing over 100 pairs of glasses to those in need.

Long Term Plan for Expanding Capacity. Using a multi-pronged, cross-departmental approach, we continuously enhance our network through innovative alternative access points and enhanced infrastructure to address needs identified through our continuous network monitoring. Our long-term strategies aim to expand network capacity in all regions, including rural and frontier areas, to improve members' access to care. Investments to increase member access to care include:

- **PROJECT ACCESS**. Centene and Nebraska Total Care are partnering with The Health Center Association of Nebraska (HCAN) to establish ***PROJECT ACCESS.*** Our partnership focuses on increasing member access to care via FQHCs through competitive compensation, improved clinic operations, and increased capacity. PROJECT ACCESS includes:
  - ***Recruitment funds*** to assist FQHCs in offering more competitive compensation packages through incentives such as sign-on bonuses, loan forgiveness, continuing education, licensure expenses, and/or relocation assistance.
  - ***Clinical optimization funds*** for FQHCs to improve operational processes for member scheduling and throughput. Funds can be used for hiring consultants to review processes or upgrading technology.
  - ***A capital request process*** to increase access by adding physical capacity to serve underserved populations. This could include increasing capacity at an existing location, expanding telehealth capabilities, developing mobile programs (such as a dental van), and/or advancement of new projects.
  - ***A Steering Committee*** to create a think tank of community stakeholders to evaluate workforce factors and how to

attract employees to FQHCs. The steering committee will seek out other community stakeholders in the education and health care fields, such as universities, colleges, and trade associations.

"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., Chief Executive Officer, Health Center Association of Nebraska

- **Telehealth Access Expansion Grants**. We offer grants to providers that improve health equity in areas of the State where access can be enhanced through telehealth. ***In 2021, Nebraska Total Care and Centene issued a grant to Heartland Health Center (FQHC) through this telehealth grant program.*** They used a majority of the grant to buy home medical monitoring equipment for several members with higher-risk medical needs to support self-management through health monitoring at home. Nebraska Total Care purchased tablets to support telehealth visits for members and providers, reducing the need to see members in the office during the pandemic to reduce the spread of COVID-19.
- **Telehealth**. We are investing in a thoughtful telehealth strategy to bring greater health care access to rural and frontier communities in the State. Our innovative solutions build provider capacity, increase access to diverse and high-quality specialists, improve integrated management, and improve member and provider satisfaction. The following telehealth offerings will meet physical health, BH, and dental needs and enable timely access to care:
  - **Virtual Visits for Urgent Care and BH.** All Medicaid members enrolled with Nebraska Total Care will have access to ***Babylon Health's telehealth platform***, which uses leading-edge digital technology and artificial intelligence symptom-checking tools to triage members and determine the correct point of care. Through Babylon, members can initiate two-way video and/or audio virtual visits for pediatric and adult urgent care needs, as well as BH services, including therapy, psychiatric care, prescription management, and preventive care, while maintaining accessibility for members with disabilities or limited English proficiency.
  - **Virtual PCP Program.** We are piloting the ***Babylon 360 Virtual PCP program (Babylon 360)***, an innovative program to address member Social Determinants of Health (SDOH) barriers and health disparities, increase access, and advance health equity. Through this model, we can identify members with low primary care utilization and support them via telehealth PCP services. Our Care Management team and Babylon's Care Advisor work together to provide Care Coordination and educate members on benefits, resources, and Care Management programs.
  - **Virtual Community Mental Health Center (CMHC).** We offer Brave Health, a virtual CMHC 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 focuses on 7- and 30- day follow-up visits after an inpatient admission to support HEDIS measure improvements and reduce inpatient readmissions.
  - **Specialty Physician eConsult Solution.** To support integrated care delivery, we offer ConferMED, a specialty physician eConsult solution that enables asynchronous, store-and-forward consults between PCPs and specialist providers. This platform will expand specialty care access, decrease service wait times, and reduce avoidable specialist visits, tests, and procedures. Historically, 80% of eConsults result in a recommendation that prevents the need for a specialty care visit, supporting members in getting the care they need at the right time. This option promotes the ability to share documentation and coordinate care for members.
  - **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 bring teledentistry services to primary care, BH clinics, and school-based health centers. We will explore partnerships with local universities to expand its teledentistry program, allowing dental providers in rural areas to conduct member consultations through two-way audio/video with dental specialists at the college. Teledentistry equipment connects to diverse sites in nine communities around the State, including a hospital and community health center.
  - **Pomelo.** 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%. Pomelo's virtual model increases our members' access to this verified approach to reducing preventable NICU stays.

34. Describe the Bidder's required PCP responsibilities and how the Bidder will verify PCPs are performing them.
Page Limit: 2

PCP Responsibilities

The Primary Care Provider (PCP) is the cornerstone of Nebraska Total Care's service delivery model and serves as the Patient-Centered Medical Home (PCMH) for the member. The PCMH concept facilitates a strong member-provider relationship, supports continuity of care and member safety, eliminates redundant services through care coordination, and ultimately leads to cost-effective care and better health outcomes. We offer a comprehensive network of PCPs, ensuring every member has access to a Medical Home within the required travel distance standards (two PCPs within a 30-mile radius of each member's residence in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties).

Members with disabling conditions, chronic illnesses, or children with special health care needs may designate a specialist as a PCP in consultation with the current PCP, member, and the specialist. The specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the members disabling condition, chronic illness, or special health care needs. Provider specialty types that may serve as PCPs include:

- Family and General Practitioner
- Internal Medicine
- Pediatrician
- OB/GYN
- Advanced Practice Nurses and Physician Assistants practicing within the scope of their license

We outline the following PCP contracted responsibilities in the Provider Handbook. Additionally, we include this information on our public website and secure Provider Portal:

- Establish and maintain hospital-admitting privileges sufficient to meet the needs of all linked members with at least one hospital within the required network adequacy distance requirements
- Manage the medical and health care needs of members to assure that all medically necessary services are available in a culturally competent and timely manner while ensuring member safety, including for members with special needs and chronic conditions
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide screening, well-care, and referrals to community health departments and other agencies by DHHS provider requirements and public health initiatives
- Maintain continuity of each member's health care by serving as the member's Medical Home
- Offer hours of operation no less than the operating hours offered to commercial members, or comparable to commercial health plans if the PCP does not provide health services to commercial members
- Provide referrals for specialty and subspecialty care and other medically necessary services
- Ensure follow-up and documentation of all referrals including services available in the State's fee-for-service program
- Participate with Nebraska Total Care's Care Management program regarding performing member screening and assessment, developing a plan of care to address risks and medical needs, and linking the member to other providers, medical services, residential, social, community, and other support services as needed for physical or behavioral illness
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including services provided by the PCP, specialists, and providers of ancillary services
- Adhere to the EPSDT periodicity schedule for members under age 21
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; including coordinating services the member is receiving from another health plan during the transition of care
- Share results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned, so services are not duplicated
- Transfer members' medical records to the receiving provider upon the change of PCP at the request of the new PCP and as authorized by the member within 30 calendar days of the date of the request
- Allow use of practitioner performance data for Nebraska Total Care quality improvement activities
- Maintain the confidentiality of member information and medical records
- Actively participate in and cooperate with all Nebraska Total Care quality initiatives to improve members' quality of

care and services (cooperation includes collection and evaluation of data)
- Provide notice to Nebraska Total Care of any updates to the physician directory such as a new address, new phone number, or change in group practice affiliation at least 30 days before the effective date of such changes, as possible

We request that PCPs inform our Member Services department when a member misses an appointment so we can monitor and conduct outreach on the importance of keeping appointments. Our outreach has contributed to decreases in missed appointments and reduction in inappropriate use of ED services.

Processes to Verify PCP Performance

Nebraska Total Care verifies that PCPs are performing all required responsibilities through quarterly access and availability audits, member feedback, member satisfaction analysis (CAHPS surveys), and PCP education and performance improvement processes. An important component of our PCP performance verification process is regularly reminding providers that performance results are directly tied to VBP initiatives and that high levels of performance correspond with earned incentives and bonuses.

Quarterly Access and Availability Audits. Nebraska Total Care uses quarterly access and availability audits to verify that PCPs are performing all required responsibilities related to open/closed panel status, appointment availability, and in-office wait times. When a provider is non-compliant with access and availability standards, we work with the provider to identify and solve the root cause, with education and corrective action measures to address noncompliance.

Member Education and Satisfaction with PCPs. We educate members about PCP responsibilities and monitor member satisfaction and grievances to verify that PCPs perform all required responsibilities. We include information about the PCP's role and services provided, how to choose a PMCH, and the PCP's role in the Member Handbook. We include the name and telephone number of the member's PCP on member ID cards.

PCP Education and Performance Improvement. Nebraska Total Care educates PCPs about their responsibilities and conducts performance improvement processes, including provider profiling, peer comparisons, and PCP report cards, to verify performance and assist PCPs in meeting all responsibilities. For example, we provide ongoing education and training on culturally and linguistically appropriate service delivery, through a combination of face-to-face, teleconference or web conference, and pre-recorded sessions. We create provider tip sheets and quick reference guides for topics where we see a particular need or trend, so providers have a quick reference for important issues.

Our performance improvement processes include ***Quality Practice Advisors (QPAs)*** who educate providers on their responsibilities and support PCP performance by:

- Establishing and fostering a healthy working relationship between large physician practices, Independent Physician Associations, and Nebraska Total Care
- Providing education and support for improving HEDIS measures, medical record documentation, and coding
- Assisting in resolving deficiencies impacting compliance with State and Federal standards for HEDIS measures
- Supporting quality improvement interventions and audits

"OneWorld's value-based contract with Nebraska Total Care is quite sophisticated... We also have been able to partner with them to understand and reach out to those patients who have not sought care from us. These are patients who have selected us as their primary care provider, but have not had a patient visit yet. They have suggested outreach solutions to ensure that these members get access to preventive care. So our work together is helping to get patients connected to a primary care clinician..."

- Kristine McVea, MD, MPH, Chief Medical Officer, OneWorld Community Health Center

35. Describe innovative strategies the Bidder intends to use to identify physical health and dental specialty types for which member access is limited. Describe the Bidder's intended initiatives for increasing the number of specialists within those specialty types that participate in the Bidder's network.
Identify potential challenges the Bidder anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the Bidder will mitigate those challenges.
Page Limit: 3

Innovative Strategies to Identify Specialty Types for Which Access is Limited

Nebraska Total Care recognizes that the provider community includes specialty providers who do not have the capacity to serve or have elected to not accept Medicaid members. Additionally, Nebraska's urban, rural, and frontier geographies contribute to specialty access challenges, as rural and frontier populations are medically underserved experiencing increased health disparities and social needs. Workforce shortages are more prevalent in rural and frontier areas within Nebraska, such as among psychiatrists and other Behavioral Health (BH) and substance use providers, and pediatric and adult physical health specialists such as cardiologists and neurologists.

We routinely complete a comprehensive analysis of service accessibility that considers geographic and social obstacles and pinpoints community resources necessary to develop solutions. To bridge the barriers we identify, we employ a range of innovative initiatives to increase the number of specialists and remove barriers to accessing specialty care.

Specialized Targeted Analyses. We identify specialty types for which access is limited through sophisticated data analytics, input from members, providers, and stakeholders, and our Health Equity Improvement Model.

- **Quest Analytics Analysis Based on Provider Specialty.** We use Quest Analytics, the same tool employed by CMS to measure geographic access, to identify limited access specialties and other network gaps. The tool enables us to conduct condition-specific analysis and provides heat map functionality to help us evaluate our network to ensure we are providing appropriate access to specialty care for conditions such as diabetes.
- **Facilitating Continuous Input**. As part of our rural health strategy, we build relationships and processes to facilitate ongoing input to inform our innovative approach to improving access to care. In addition to our standing committees that include members, providers, community-based organizations, associations, and other stakeholders, we utilize surveys, grievance and complaint data, care coordination issues with accessing available providers, claims review, and feedback from our local Provider Relations Representatives to identify gaps in our network.

Initiatives to Increase Specialty Network Access that is Limited

Nebraska Total Care takes a multi-faceted approach to support equitable access. We customize our strategies based on our local presence and awareness of geographic and provider limitations, especially for high-volume specialists in rural and frontier counties. Our initiatives include:

Contracting with Border Providers. Nebraska Total Care recognizes that in rural and frontier areas, specialty providers are not available within the distance standards. In such cases, we identify the nearest provider available based on the patterns of care. We work with providers across state lines in Kansas, Iowa, South Dakota, Colorado, and Wyoming to provide specialty care based on members' needs. For example, we have agreements with Sanford Health System, Avera Health, and Monument Health in South Dakota to serve members in northeast Nebraska, Colorado-based HCA Healthcare, and Wyoming-based Cheyenne Regional Medical Center to serve members in western areas of the State.

"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 kepy in frequent communication with the team at Boston Children's. Many of our patients have lengthy admissions and the tean at Nebraska Total Care was able to work with the family to cover travel and lodging exepnses, which was a great relief to the family. "

- Julia Thomann, LICSW, Outpatient Clinical Social Worker, Esophageal Airway Treatment Center
Department of Plastic and Oral Surgery, Boston Children's Hospital

Leading Innovation and Best Practices

Telehealth and Teledentistry. We know some areas within Nebraska lack certain physical health (PH), BH, and dental specialty providers in rural and frontier areas. To address these gaps and improve access to holistic, person-centered specialty care, we use telehealth strategies to expand provider-to-member encounters and provider-to-provider consultation capacity. We are partnering with providers like the ***Health Center Association of Nebraska (HCAN) to increase access to services through FQHCs, including telehealth services***. (See question 33 for details on our partnership with HCAN on ***PROJECT***

Provider-to-Provider eConsults. We leverage ConferMED to support our rural primary care providers to connect with specialists across the State, promoting health equity and enabling them to overcome geographic barriers and treat members in their community at the top of their scope of practice. In addition, we use ConferMED to promote and support efforts that integrate primary care services within specialty BH settings and support primary care based BH for pediatric populations. For example, our affiliate in Indiana used ConferMED to remove access barriers for Heart City Health Center, an FQHC located in Elkhart County. As a result, the eConsults have shown to decrease the total cost of care by maintaining members within primary care and reducing the need for referrals to providers outside of their community.

HCAN-FQHC Recruitment Fund. We know from our discussions with HCAN and their FQHC members and community stakeholders, that there is a shortage of providers and the FQHCs have difficulty recruiting providers, particularly in rural areas of the State. For example, in Nebraska, 13 of 93 counties currently do not have primary care physicians, 44 counties do not have OB/GYN physicians, and 78 counties do not have practicing psychiatrists. ***Nebraska Total Care will partner with HCAN to establish a Provider Recruitment Fund for FQHCs in the State of Nebraska. This fund will be administered by HCAN for the use of recruiting PH, BH, and dental providers, including hygienists.***

Mobile Dental Van Flossy. Our affiliate, Envolve Dental, Inc. (Envolve Dental) will provide free same-day dental screenings and fluoride varnish services by dentists and hygienists through a mobile dental service called ***Flossy***. Envolve Dental brings this mobile clinic straight to the community (beginning in the summer of 2022), offering high-quality dental care and education for adults and kids with oral health disparities. To support access to equitable routine dental health services for Nebraskans Flossy can:

- Obtain fluoride varnish for both children and adults who need the service. This offering was added to fill the gap and help prevent dental cavities in individuals who do not receive regular preventive care.
- Have a safe place to discuss their concerns about dental care
- Learn best practices for dental care, whether provided by self, parent, guardian, or caregiver
- Receive fun and practical giveaways like toothbrushes and floss
- Learn how dental care is tied to their overall health

Traveling Specialists. Nebraska Total Care continues to seek partnerships to expand access to traveling specialists. Some partners, like Catholic Health Initiatives (CHI), the University of Nebraska Medical Center (UNMC), Children's Hospital, and Bryan Health already offer a selection of traveling specialists.

Approaching Existing Specialty Providers to Expand Access. Nebraska Total Care approaches select specialty provider partners to encourage them to consider traveling to/expanding into areas where access is limited. Facilities such as Fillmore Community Hospital and Morrill County Community Hospital are expanding to rural and frontier members by increasing capacity at their physical sites to deliver outpatient services. By partnering with these facilities to gain an understanding of high-demand and low-supply specialty services, we ensure that clinics are being used and members are served locally.

Pathways Program Increases Specialty Access for Members with I/DD. Thirty-two years after the passage of the Americans with Disabilities Act in 1990, individuals with intellectual and developmental disabilities (I/DD) commonly do not have access to quality specialty medical care professionals because of fear and misunderstanding of disability. In partnership with Munroe-Meyer Institute at the University of Nebraska Medical Center, we support the provision of a whole-person approach that focuses on building network capacity to support specialty access needs of members with I/DD.

Nebraska Total Care is focused on increasing provider capacity to meet the needs of members with I/DD. We provide educational courses to stakeholders involved in serving members with I/DD such as medical and school personnel, families, I/DD providers, and health plan personnel. We identify and encourage the use of best practices and connect stakeholders to resources that better equip them to serve members with I/DD, increasing access to appropriate services. We balance provider access guidelines with member needs. If, for example, a Care Manager recommends that a member with I/DD visit an OB/GYN who has experience serving individuals with I/DD but the provider location is beyond the prescribed access distance parameter, we arrange for transportation to and from the specialist.

"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."

- Sharon Votava, Director of Payer Relations, Madonna Rehabilitation Hospital

Challenges to Member Access to Specialty Services and Mitigating Strategies

Nebraska Total Care takes action to ensure that members do not face barriers to specialty service access. Our community-based Provider Relations staff work daily with local providers and stakeholders to understand available resources and gaps in specialty care in each community we serve. We combine this frontline insight with our routine data analysis and stakeholder (member, provider, family, community organization) input. ***Table 35.A*** outlines challenges to specialty care access and Nebraska Total Care's strategies to reduce them.

Table 35.A Nebraska Total Care identifies and addresses challenges to member access to specialty services.

Challenges	Mitigation Strategies
Geographic limits to specialty service access	Strategies include: • Use of traveling specialists • Telehealth services delivered by Nebraska licensed providers • Mobile solutions such as dental and vision vans • Building partnerships with Primary Care Providers (PCPs) and FQHCs to implement initiatives to enhance PCP and specialty provider access in rural and frontier counties • ***PROJECT ACCESS*** to focus on increasing member access in FQHCs through more competitive compensation, improved clinic operations, and increased capacity
Specialty access among Native American members	As part of our rural health strategy, we have a focused commitment to elevating Tribal voices. We partner with off-reservation specialist providers to engage members via on-reservation Care Coordination staff through our traveling specialist and telehealth programs. For example, our agreement with Avera includes access to BH specialists through telehealth, exclusively directed toward meeting the needs of tribal members.
County/Region resource constraints that limit specialty service access	We recognize that counties and regions lack the assets and economic resources necessary for specialty practices. Nebraska Total Care bolsters access to services by arranging for telehealth and partnering with regionally impactful systems, including Children's Hospital and Medical Center for provider recruitment.
Specialty services not available in network	When a specialty provider is not in-network or amenable to joining our network, we arrange care through OON authorizations or a single case agreement (SCA). These options allow non-participating providers to see members for services for a specific length of time without requiring them to join the network.
Access to dental services	We will partner with our dental services vendor, Envolve Dental, to promote provider recruitment and existing teledentistry. For example, during the Public Health Emergency, when access to dental services became challenging, our affiliate partner partnered with Envolve Dental to quickly pivot and arrange for teledentistry for members.

36. Describe the Bidder's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times ***Page Limit: 2***

Nebraska Total Care complies with all appointment availability and wait time access standards per Scope of Work Attachment 14 – Access Standards. We audit compliance with appointment access and wait time standards, and 24-hour physician availability, through our ***formal quarterly audit program.*** We complete all audits in a non-punitive way, we provide follow-up education and remediation led by our Provider Relations and Contracting and Network Development staff. We monitor compliance with access standards by analyzing CAHPS member satisfaction survey and provider satisfaction survey, member and provider complaint/appeal data, utilization management, and other data. Insight from our Member/Provider Advisory Committees and input from call center inquiries are used to identify and address gaps in appointment availability and access standards.

Monitoring Adherence to Appointment Availability and Wait Times

Nebraska Total Care's Contracting and Network Development team deploys prospecting, network analytic, and geo-map monitoring capabilities to ensure we meet or exceed requirements for access and availability. We use Quest Analytics technology to continuously analyze accessibility and target network adequacy. Quest Analytics produces provider access reports to highlight network adequacy issues at the State, region, county, city, zip code, and provider type levels. The reports look at the number, type, and location of providers compared to member residential locations, highlighting any variance to network access standards. We can filter the analyzed data by member type (children, adults), provider panel status (open, closed, existing members only), provider types (including telehealth presentation sites), and more to identify network improvement opportunities.

We go beyond simply making sure members have access to providers within time and distance standards, by leveraging predictive analytics to review cultural and linguistic needs, health disparities, and Social Determinants of Health (SDOH) needs. Our Neighborhood, Economic, and Social Traits (NEST) predictive analytics 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 providing insight into the social, economic, and environmental conditions of members. We use this data to recruit the right providers with the capacity to serve members from diverse cultures and develop community-driven initiatives.

Appointment Availability Quarterly Audit Program. Nebraska Total Care follows the same approach to audit compliance with standards for urgent/non-urgent Primary Care Providers (PCPs), pediatric, OB/GYN, lab, x-ray, and specialty provider appointment availability and wait times, and 24-hour physician availability. We assess urgent care and emergency providers for appointment availability, and we audit hospitals for compliance with appointments for non-emergency hospital stays. We will add dental access standards to our audit program to include appointment access and wait time standards outlined in Attachment 14 of the contract. We conduct quarterly appointment availability audits and reports for our Behavioral Health providers.

Method and Frequency of Audits. Nebraska Total Care audits 25% of our contracted provider network each quarter to assess compliance with one or more of the appointment availability standards. Auditors review contact information such as an address, phone, fax, email, and open panel status.

Addressing Deficiencies. Within 14 days of receiving audit results, Provider Relations staff reach out to non-compliant providers to re-educate them about access standards, specifically discussing areas the provider failed to meet. Our Provider Relations staff solicit feedback from the provider and their staff to identify barriers to meeting timely access for appointments and together agree on specific interventions. We require providers to implement proposed interventions within seven calendar days; our Provider Relations staff re-survey the provider in the following quarter to determine if they have demonstrated compliance with standards.

If a provider fails to demonstrate compliance after a subsequent audit, Nebraska Total Care provides written notice (within 14 days of receiving audit results), documenting the area(s) of non-compliance and requesting that the provider submit a written ***Corrective Action Plan (CAP)*** within seven calendar days. The CAP must outline the steps and processes the provider will implement to bring the practice into compliance with standard(s).

Appointment Availability

Nebraska Total Care's appointment and availability survey results exceeded our minimum standard of 95%.

- 97% of PCP offices had preventative care appointments available within 28 days, and urgent appointments in the same day.
- 100% of specialists had appointments available within 30 days.

Our ***Peer Review Committee*** evaluates providers who remain non-compliant and provides recommendations, such as focused monitoring. The Committee may refer providers to the ***Quality Assessment and Performance Improvement Committee (QAPIC)*** for consideration of continued network status.

Surveys and Feedback. While compliance audits provide objective data on provider performance, Nebraska Total Care also collects qualitative data to assess performance. We administer annual member and provider satisfaction surveys and identify access-to-care strengths and opportunities, along with other key information. We recognize the importance of member feedback and satisfaction regarding timely treatment. We give members a voice by encouraging and educating them to report appointment availability access issues through our Member Services Call Center or our Member Portal's secure messaging tool. Appointment availability is also a standing agenda item in our quarterly Member Advisory Committee and provider Joint Operating Committee meetings.

High Satisfaction Scores

Nebraska Total Care's 2021 CAHPS scores for member satisfaction were **91.4%** for "**Getting Needed Care**" and **92.4%** for "**Getting Care Quickly**".

We are rated ***number one in provider satisfaction among Nebraska Medicaid MCOs.***

Quality Oversight. Nebraska Total Care's Quality Assessment and Performance Improvement Committee (QAPIC) reviews audit results quarterly and member and provider survey data annually as part of the annual QAPI program evaluation. The committee analyzes results to identify trends indicating access problems and provides recommendations to our Contracting and Network Development and other staff for resolution if access issues are found.

Taking Actions to Ensure Adherence to Appointment Availability and Wait Times

Over the past seven years, Nebraska Total Care has built and maintained a network that exceeds standards for providing timely access to care for members. ***As of today, we have no provider network gaps with available provider supply***; the only network gaps are in frontier counties where there are no providers available within the distance standards. For high-volume specialties, our network exceeds State access standards outlined in Attachment 14 when a provider is available. We have intentionally chosen to avoid narrow models that require a referral or prior authorization, limit member choice, and block or delay access to care. If we identify that a provider has a wait list, we refer the member to another appropriate provider. We stop referrals to any provider that maintains a wait list until they have an opening. If the member is on a wait list for residential behavioral health services, we work with providers to arrange for interim services that meet the member's needs until residential services are available.

Our expansive network includes all willing Essential Community Providers and FQHCs, operating where members live. We align with the highest quality providers and develop innovative solutions to bring new services that strengthen our network. ***Our efforts to support providers and reduce administrative burden have led to an increase in provider satisfaction and provider retention.*** Continual and consistent monitoring of our provider network is vital to maintaining these standards, enabling us to identify and quickly remediate any gaps and ensure members have ongoing access to high-quality care.

Provider Education. Nebraska Total Care educates providers about appointment access and wait time standards through our New Provider Orientation, ongoing training programs, Provider Handbook, and our website. We use bi-weekly email newsletters and quarterly Provider Newsletters to remind network providers of the appointment availability, wait time, and after-hours access requirements as specified in provider contracts.

All provider communication efforts emphasize the critical connection between provider performance based on quality measurement review and results, including appointment availability and wait time standards and incentives earned through our Value-Based Purchasing initiatives. Our Provider Relations staff educate providers during face-to-face visits inquiring about their knowledge of and ability to meet standards. When there is an obvious barrier to meeting standards, our Provider Relations staff work closely with the provider to identify interventions to bring them into compliance.

37. The Bidder must describe in its response to the RFP its methodology for promoting patient centeredness/PCMHs within its provider network. The plan should include, but is not limited to:
i. Provision of technology assistance to assist providers in the implementation of patient centeredness, including, but not limited to, electronic health record funding;
ii. Any payment methodology, such as incentive payments, to PCPs to support this transformation;
iii. Provision of technical assistance to assist the PCP's transformation to PCMH recognition (including education, training tools, and data relevant to member clinical care management);
iv. Facilitation of specialty provider network access and coordination to support patient centeredness;
v. Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as coordination of services with specialty behavioral health providers and other community services;
vi. Facilitation of data interchange among PCPs, specialists, laboratories, pharmacies, and other appropriate providers; and
vii. A methodology for evaluating the level of provider participation and the health outcomes achieved. MLTC will work with the MCOs to develop a common evaluation methodology. The findings from these evaluations shall be included in the MCO's annual quality evaluation report.
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Methodology for Promoting Patient Centeredness/PCMH within our Network

Promoting PCMHs

Nebraska Total Care contracts with 100% of qualified Nebraska PCMH recognized providers.

Nebraska Total Care has a variety of tools, processes, and supports that meets providers where they are in their journey towards PCMH practice transformation. Tools and supports are customized based on the provider's level of interest, readiness, and size of the practice. We support network providers in achieving recognition as PCMHs and promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, member-centered, and coordinated Care Management processes. We support providers in obtaining either NCQA Physician Practice Connections® PCMH recognition or The Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation. Certification benefits include:

- **Members** – access to high-quality healthcare that fosters self-management, improved member experience, improved access such as after-hours care, better chronic condition management, and better coordination of Physical Health (PH)/Behavioral Health (BH).
- **Providers** - higher level of plan support, an opportunity for embedded Care Managers, financial incentives, a suite of reports to help manage their practice, reduced fragmentation, improved team-based care and coordination, and preferential member assignment for high-quality providers.
- **State of Nebraska** - reduction in the total cost of care and improved outcomes.

Nebraska Total Care currently has ***100% of qualified Nebraska PCMH recognized providers in our network***. We are working with multiple PCMH providers, including those affiliated with ***Children's Hospital and Medical Center***, to move them into Value-Based Purchasing (VBP) agreements. Many PCMH providers have already moved to VBP agreements, including ***OneWorld, Bluestem, Nebraska Medicine, Nebraska Methodist, and Catholic Health Initiatives (Common Spirit Health)***.

Technology for Providers to Support Patient Centeredness

Through our Technology Enablement Fund, we support Electronic Health Record (EHR) use and development. We assist providers in applying for available grants to fund EHR implementation, particularly for small practices without the resources to pursue these funds. Additionally, we provide Health Information Exchange (HIE) and EHR support and incentives. We encourage use of Nebraska's designated HIE, CyncHealth, for PCMHs to access member information and records in real-time from primary care providers (PCPs), hospitals, clinics, labs, pharmacies, and individual providers across Nebraska, including access to Children's Hospital emergency medical records to support authorization completion. This enhances Care Coordination and reduces the administrative burden on clinicians and hospital staff.

We support all providers in accessing timely data through our secure Provider Portal: a web-based platform supporting physical and behavioral health provider administrative and clinical applications. The Provider Portal includes care gap health alerts, a member health record, admit discharge and transfer (ADT) notifications, Patient Analytics, Provider Analytics, Care and Disease Management referral, and clinical practice guidelines. Our Provider Portal supports providers in their practice of evidence-based medicine and provides access to administrative self-service capabilities including:

- Member search and eligibility check
- Claims submission status, and payment history
- Prior authorization submission and status
- ED notifications

- Member panel roster, including care gap alerts
- Patient Analytics Dashboard, including disease registries
- Provider Analytics Dashboard, including cost and utilization trending
- Member Health Record, including ADT events, care plans, record of visits, medications, labs, and immunizations

Payment Methodologies and Incentive Payments to Support Transformation

Nebraska Total Care values our provider partnerships and fosters a collaborative environment that encourages and rewards high performance and supports the delivery of high-value care. Informed by our experience and feedback from providers and MLTC, we have developed an array of payment methodologies to encourage PCPs to provide person-centered care and improve health outcomes, member adherence, and member satisfaction. We tailor our VBP approach to align provider success with improving member wellbeing, driving meaningful improvements in health and health equity. ***We incentivize providers to attend integrated care training and offer rewards for achieving PCMH recognition and improved member outcomes***. We use a multi-dimensional provider incentive program, including financial and non-financial incentives, to reward and encourage providers at various stages of transformation, including:

- **Performance-Based Incentives**. Practices that meet or exceed pre-established performance targets can receive enhanced incentive payments.
- **Incentives to Achieve PCMH status**. We encourage practices in medically underserved areas or that primarily serve populations with identified health disparities to pursue PCMH status. We offer incentives and expertise to support them through the PCMH transformation process. We provide enhanced technical support to build the infrastructure needed to transition to a PCMH model through our ***Technology Enablement Fund***.
- **Incentives to Address Health Equity**. Our new Equity-Based Contracting model will financially invest in providers who care for members with high health disparities. Equity-based contracting is specifically designed to encourage, enable, and measure adoption of person-centered, culturally, and linguistically appropriate care that integrates physical, behavioral, and social health.
- **Member Assignment**. When a new member has not self-selected a PCP at enrollment, we have implemented preferential auto-assignment to PCPs who are recognized as PCMHs.

Technical Assistance to Assist PCP Transformation to PCMH Recognition

Nebraska Total Care assists providers to achieve PCMH recognition through our ***NCQA Content Expert Certified PCMH Coordinators***. Our technical support model includes access to nationally recognized readiness tools, education on becoming certified, resource tools, and best practices. Our secure Provider Portal offers tools to support PCMH accreditation, including online care gap notification and detailed member panel rosters. Our goal is to support all practices at various stages of practice transformation and transition them towards full PCMH recognition.

PCMH Champions. Once a practice is interested in pursuing PCMH status, we leverage our PCMH champions (such as Children's Hospital), to guide interested practice staff and providers through the PCMH process.

Supporting Practices Throughout the Transformation Process. For all providers working towards PCMH status, we provide enhanced support based on their specific needs and situation. Our ***NCQA Content Expert Certified PCMH Coordinators*** develop a work plan for the practice and timeline for staff training, assess current workflows, and help the practice develop policies and procedures to support revised work processes. Coordinators meet with the practice regularly to assess progress, provide direction, and assist with problem-solving. All services and training are easy to access to ensure physician and staff engagement.

Regional Small-Practice Support. Because Nebraska has so many small provider practices that need added support, we provide a dedicated ***Small-Practice Support team,*** assigned to multiple providers within a common geographical area. These teams provide one-on-one practice assistance and joint training among several offices that can benefit from common experiences and challenges. ***Regional Care Managers*** work with providers and their staff to provide intensive technical support and training to meet providers where they are, making sure they understand and can effectively use the tools we offer to manage their practice and support Care Coordination. Providers are invited to participate in ***regional PCMH learning collaboratives,*** to discuss PCMH training, share experiences and lessons learned, and identify best practices.

Clinical Training. We offer provider training and education courses through our comprehensive clinical training program, both in person and via webinar. We designed our provider training to enhance the knowledge, skills, and performance of health care professionals who empower members to make positive health behavior changes and promote the member-provider relationship. Our trainers have extensive knowledge in a variety of topics, including BH, nursing, exercise physiology, Case and Utilization Management (UM), and Care Coordination. We offer many free courses to enhance

integrated care and expand the use of best practices. Participants receive BH and nursing continuing education credit for certain classes or certificates of attendance related to certain licensing requirements.

Specialty Provider Network Access and Support

We make it easy for members to access specialty care providers through our comprehensive network and Find-a-Provider tool. We help members and providers locate specialty care providers (including dental health), make referrals, and schedule appointments.

Facilitating and Managing Referrals. We work closely with PCMH providers to facilitate referrals for prior authorization (PA) services. Providers can use the Pre-Auth Check tool on our website to determine if a referral service requires PA and can submit PAs through our secure Provider Portal or submit via phone of fax. Providers can check the status of the submitted PA for the service referral through our Provider Portal. ***Referral Specialists*** process referral requests, many of which are approved automatically. We document all referral or PA requests in TruCare Cloud, our care and utilization management platform. We use TruCare Cloud to store referral requests for quick response by Referral Specialists.

Specialty Support. We provide training and tools to ensure providers can quickly and efficiently identify and arrange the appropriate level of specialty services and support. All providers have online access to and receive training on our clinical practice guidelines and UM requirements, which help determine when and what type of specialty services and supports are appropriate. Our interactive online provider directory, Find-a-Provider, provides multiple search options to assist PCMH providers in identifying appropriate referrals and providers to meet their members' needs based on location, specialty, gender, language spoken, ADA accessibility, and if they are accepting new patients.

Increasing and Supporting Basic BH Services in Primary Care Settings and Coordination of Services

To increase and support providers' efforts to meet PCMH and MLTC standards regarding the delivery of basic BH services in primary care settings, our Clinical Trainer provides education on practice guidelines, principles of recovery and resilience, and the use of screening tools for BH conditions commonly encountered in primary care settings, such as:

- PHQ-9 to screen for depression
- Edinburg Depression Screen to screen for postpartum depression
- CAGE to screen for issues related to alcohol use
- GAD-7 to screen for general anxiety disorder
- SBIRT to identify substance misuse and appropriately refer for treatment; Nebraska Total care reimburses providers as a Value Added Service

We will continue supporting providers in their ever-expanding adoption of telehealth capabilities to augment the ability to treat basic BH conditions in the primary care setting. This is specifically impactful for members in rural and frontier counties. We have aligned with MLTC's guidance about the public health emergency (PHE)-related changes to telehealth offerings, and telephonic-specific changes afforded to established patients in rural and frontier counties through the passing of LB400 in the most recent Nebraska State Legislative session. We offer the following telehealth solutions to support BH service delivery:

- **Babylon 360 Virtual Care.** We are piloting Babylon's 360 Virtual PCP Program, an innovative virtual Value-Based Purchasing (VBP) program to remove member SDOH barriers and health disparities, increase access to BH services, and advance health equity.
- **Brave Health.** We offer Brave Health, a virtual Community Mental Health Center platform and model providing child, adolescent, and adult psychiatry; therapy; substance use disorder (SUD) care; hospital transition support; medication adherence intervention; and health navigation engagement telehealth services.
- **ConferMED** To support integrated care delivery, we offer ConferMED, a specialty physician eConsult solution that enables consults between PCPs and PH/BH specialists. ConferMED expands specialty care access, decreases service wait times, and reduces avoidable specialist visits, tests, and procedures.

Coordination of Services with Specialty BH Providers and Community Services. Provider Relations staff identify providers with whom we can establish agreements for formal and informal resources and programs, such as rehabilitation programs, recovery support services, and anonymous recovery programs. We encourage larger primary care practices to integrated BH screening and brief intervention into workflows and to hire BH professionals to integrate BH into primary care settings. Our Care Management teams are integrated and cross-trained in managing PH and BH conditions and coordinating member services.

Facilitating Data Sharing with Providers

To deliver information closer to the point of care, PCPs, hospitals, labs, pharmacies, other providers, and HIEs, including ***CyncHealth***, can interface with our ***Clinical Data & Interoperability Gateway*** for standards-based data interchanges,

including Health Level Seven (HL7) Fast Health Care Interoperability Resources (FHIR). For example, we currently receive ADT data from CyncHealth and display ADT notifications through our secure Provider Portal to facilitate timely communication with providers. We will support additional care coordination data exchanges through CyncHealth via standards-based Continuity of Care Document (CCD) transactions (for example, care plans, care gaps, SDOH) and are working with CyncHealth to promote the sharing of dental records within their HIE platform. We also support ***EPIC EMR*** integration, one of CMS' adopted industry standards, which will facilitate use cases through bi-directional data sharing with provider 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. Through these data sharing initiatives, providers are better able to take timely action and achieve results without adding more complexity to their day-to-day activities.

Methodology for Evaluating Provider Participation and Outcomes

We support MLTC's goal of creating a common evaluation methodology. Using our vast provider, claims, and quality data, we understand and look forward to developing measurements that speak to a specific community, member, and service type experience. We generate actionable quality improvement initiatives with statistically significant improvements. A common methodology reduces provider administrative burden and creates measurable consistencies, facilitating the delivery of high-value care.

38. Describe how the Bidder would respond to the network termination or loss of a large-scale provider group or health system. Take the following areas into consideration in the response:

• Notification to MLTC.
• Coordination with the Pharmacy Benefits Manager.
• The automated systems and membership supports used to assist affected members with provider transitions.
• Systems and policies used for continuity of care of members experiencing provider transitions.
• Impact if the loss is in a geographic area where other providers of the same provider type are not available and the MCO's response to that impact.

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Proactive Risk Management and Continuous Network Monitoring

Nebraska Total Care has never received a termination of a large-scale provider group. If in the unlikely event a termination of this type does occur, we have established policies and procedures to effectively and efficiently manage network termination or the loss of a large-scale provider group or health system. We proactively monitor and manage our provider network to reduce the risk of losing a health system while remaining prepared to implement a comprehensive response that ensures continued member access and continuity of care should this event occur. Our well-developed network (including providers in bordering states), strong provider relationships, and a number-one rating in provider satisfaction allow us to identify concerns before they create a larger issue.

Notification to MLTC. Nebraska Total Care would alert MLTC of any potential termination or large-scale loss within our network before the system termination is formalized. We will contact and engage in dialogue with MLTC to resolve any significant impact the loss of the provider group or health system could have on members. We will notify the Nebraska Medicaid Program Integrity Unit in writing within three business days of learning of the potential for any significant changes to the provider network, including cases where we sever a relationship with a previously debarred or excluded individual or entity.

Coordination with the Pharmacy Benefit Manager (PBM). Our Pharmacy and Compliance Team work closely on various issues, including network adequacy. These teams regularly convene telephonically and through regular Joint Operating Committee meetings. Our PBM's electronic point of sale system feeds directly into our Management Information System (MIS), making pharmacy-related information exchanges between us and our provider network simple. Through routine communication and close coordination, we support members to seamlessly transition between network pharmacies.

Automated Systems to Assist with Provider Transitions. If a large-scale provider loss occurs within our network, our automated technology systems allow us to quickly respond and ensure access to care. Our Provider Lifecycle System, an integrated component of our MIS, allows us to manage provider transitions by tracking termination dates and changes in our network data following the loss of a provider. For member-level transition plans, our Care Management platform, TruCare Cloud, provides an integrated clinical record that includes information on Physical Health (PH), Behavioral Health (BH), dental, and specialty provider access needs; treatment goals and objectives; milestone dates; and progress in a well-organized format. TruCare Cloud's integrated member care plans are available to authorized Provider Portal users. Members can also access their care plan via their secure Member Portal account. Our online provider directory, Find-a -Provider, supports members in choosing a new provider and our Care Coordination/Care Management teams and Member Services Call Center staff are also available to assist members in selecting a new provider.

Nursing Facility Closures – Member Transition

In the past four years, 19 nursing facilities in our network closed, resulting in 170 members successfully transitioning to new facilities.

Our Care Management team assisted members and their guardians with the transition, alleviating barriers through communication and partnership between the members, facilities, and MLTC.

Systems and Policies for Member Continuity of Care. Our Provider Agreements require that providers give us 180 days notice before voluntarily leaving our network at the end of the initial term or the end of any renewal term. By having 180 days' notice, we can implement our network development strategy. The goal of our strategy is to retain, through rescission of the termination, or replace, when possible, the provider and maintain continuity of care for impacted members. In addition, providers must supply copies of medical records for each member to the new provider and facilitate the member's transfer of care, at no charge to the member or new provider.

Nebraska Total Care will allow members to continue an ongoing course of treatment from the

terminated provider (unless the provider is terminated due to cause or no longer providing services within the service area) for up to 90 calendar days from the date we notify the member of the termination, or 90 calendar days from the date of provider termination, whichever is greater. Upon request from a member receiving active treatment related to a chronic or acute medical condition, we will reimburse the provider for covered services for up to 90 calendar days from the termination date. We will also reimburse the provider for the provision of covered services to a member who is in the second or third trimester of pregnancy, extending through the completion of postpartum care.

Member Notification. Upon receipt of a provider's notification of termination, our Provider Relations department notifies our Network Management team. The Network Management team and Provider Relations staff will follow our policies and procedures to engage with the provider resolve any identified concerns. Once we initiate a plan of action to address the provider's concerns, we will request that the provider rescind the termination notice in writing. In the unlikely event that the provider does not rescind the termination, we will follow established timelines for member notification.

Within 15 calendar days of notice or issuance of termination, we mail a notification of termination to all members that received services from that provider in the past 12 months, containing the following information:

- Enrollment data to identify members with a provider who is part of the terminating group or system
- Existing authorizations of ongoing covered services, including data related to members currently receiving inpatient-level services and those with an authorization for service at a future date
- Available claims data that identifies specialists and other providers who are part of the terminating provider group or health system, who provided services to members within the past 6 to 12 months
- Pharmacy data to identify members with prescriptions written by providers who are part of the terminating provider group or health system, with a focus on medications that indicate a chronic or complex condition that may require ongoing services, including short- or long-acting beta-agonists which would indicate asthma or psychotropic medications indicating mental illness

Once Nebraska Total Care has identified members in need of a transition plan to ensure access and care continuity, we use TruCare Cloud to share information with relevant staff. We use this information to stratify transitioning members for outreach based on risk.

Member Information Transfer. Nebraska Total Care uses automated technology systems to facilitate continuity of care for members impacted by provider transitions. Our Provider Portal gives new providers access to information about the member's care history, including identified needs, services received, and pharmacy information. To ensure there is no gap in care, our Care Management teams coordinate with the member/caregiver, the existing provider who is leaving the network, and the new provider, develop a plan for safely transitioning care to the new provider, and ensure the care plan continues to address the member's needs and preferences.

Ensuring Continuity of Care

Our Care Management team **coordinates with providers within 1 business day** of becoming aware of the transition to ensure continuity of care for members for which a delay could jeopardize their health.

Care Managers use TruCare Cloud to document the transition plan, adjustments to treatment goals, and other Care Management actions. Care Managers assist with medical record transfer, educate the member about the transition plan, assist with scheduling appointments with the new provider, and arrange transportation to services. When disruption of services could potentially jeopardize member care, our Care Management team ***outreaches to the receiving provider within one business day*** of becoming aware of the transitioning member, including under the following circumstances:

- Pregnant women with high risk, in their third trimester or within 30 calendar days of the anticipated delivery
- Member has a significant PH or BH condition
- Member needs an organ or tissue transplant
- Member is receiving ongoing services such as chemotherapy or radiation
- Member has open authorization for services, including ongoing outpatient BH services, scheduled surgeries, post-operative follow-up, or out-of-area specialty care
- Member is currently in an inpatient facility
- Member is engaged in Care Management and requires significant, complex Care Coordination support

Nebraska Total Care will allow members undergoing an active course of treatment to access services from non-contracted providers for 90 calendar days to ensure continuity of care.

Impact of Geographic Loss Without Similar Provider Types. If the loss is in a geographic area where other providers of the same type are not available, we will take the following actions:

- Identify and/or attempt to ***recruit providers in close proximity*** who are willing to provide care to transitioning

members; we will utilize ***local leads*** (e.g., members and advocates from Nebraska Total Care advisory committees), who can help target and recruit providers to the network and deploy ***local contracting teams***

- Arrange ***non-emergency transportation*** for high-risk members to critical treatment
- Deploy ***an issue-response team,*** comprised of Network Management, Claims, Provider Relations, and applicable clinical teams to resolve issues at the root cause of the provider termination
- Provide an ***out-of-network (OON) authorization***, and when appropriate, enter into a Single Case Agreement with a terminated provider or OON provider; attempt to engage and contract with the OON provider
- Implement initiatives to extend the network's current capacity and provide access to specialty care that is no longer available in the member's local area, such as ***telehealth and member transportation support***

Nebraska Total Care's priority is to make sure members have access to all needed services within the timeframes appropriate to their condition and circumstances.

39. Describe the Bidder's credentialing and re-credentialing process including:
• Ensuring that providers are enrolled in Medicaid and have a valid identification number.
• Identifying excluded providers and persons convicted of crimes searches.
• Using quality and utilization measures in the recredentialing process.
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Credentialing and Recredentialing Process

Nebraska Total Care maintains comprehensive written policies, procedures, and standards for credentialing, recredentialing, and ongoing monitoring in full compliance with all applicable Federal and State standards, including those required in 42 CFR 438 and 455, and applicable NCQA standards. Our procedures address program oversight, provider types, provider nondiscrimination, the application process and timelines, communication with providers, tracking of credentialing activities, the recredentialing process, and oversight of delegated credentialing and recredentialing. ***Nebraska Total Care continually meets and typically exceeds credentialing turnaround times of 30 days with a current average turnaround time of eight days for 2022.***

Nebraska Total Care Exceeds Credentialing Timeline Standards

- Our current turnaround time from completed application to credentialing is **8 days**.
- We consistently process **100% of recredentialing applications** within NCQA timeline standards.

Medicare Credentialing, Including DSNP. Nebraska Total Care uses an all-lines of business approach to credentialing to reduce provider administrative burden. In cases where an existing network provider agrees to add a program, such as Medicare, the provider's existing credentialing cycle will apply to existing and new programs. There are no new steps the provider needs to take to complete the credentialing process unless there is a difference in program requirements (for example, the provider needs to enroll with MLTC.

Dental Credentialing. Our dental services affiliate, Envolve Dental, Inc. (Envolve Dental) is NCQA accredited for credentialing and recredentialing and manages both processes for dental providers. This includes verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims, through the applicable Federal and State agencies and the National Practitioner Database. Nebraska Total Care will monitor Envolve Dental's credentialing performance to verify NCQA compliance and ensure they meet timelines to maintain a high-quality health care delivery system for dental providers and members.

Medicaid Enrollment Verification

We require that all contracted providers be enrolled with MLTC as an approved service provider. If the provider does not have a current Nebraska Medicaid ID when Nebraska Total Care enrollment is completed, our Claims Processing System prevents payment until the provider is issued a Medicaid ID. Once the Medicaid ID is issued, impacted claims can proceed with processing using the MLTC Provider Enrollment vendor effective date, Contract effective date, or credentialing approval date, whichever is later. We apply our out-of-network prior authorization rules, payment methodologies, and payment policies to services that are provided after the MLTC Provider Enrollment vendor effective date, and before the Contract effective date or credentialing approval date.

Application Process. To participate in the Nebraska Total Care provider network, providers must be a part of a delegated credentialing group or submit a completed application and supporting documentation and meet all participation requirements. We process applications submitted directly by the provider or via the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing Data Source. We perform an initial application review to confirm the provider completed all required fields and that all required documentation is attached and current. We promptly notify providers if applications or attestations are incomplete or not current and instruct them to provide missing information or an updated attestation before we can process the application.

Once the application is complete, we query the National Plan and Provider Enumeration System (NPPES) to confirm the practitioner has a current, valid National Provider Identifier (NPI). We confirm with MLTC that the provider is currently enrolled, or is in the process of enrolling, as an approved Medicaid provider. If the provider is not currently enrolled as an approved Medicaid provider, we continue the credentialing and enrollment processes and pend payments to the provider and inclusion in the provider directory until the provider obtains Medicaid approval. We communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding any incidents or audit findings that could affect provider licensure for any provider type.

We forward applications with satisfactory inquiry status to the Credentialing Department for processing. Credentialing staff ensure all provider-specified data elements and documents are included, verified, and consistent with established

thresholds. The Credentialing department verifies data using primary and secondary source verification, all of which comply with NCQA, State, and Federal requirements. For all query images and other documentation reviewed during primary source verification (including those retrieved via oral sources), we save, date stamp, initial, and place it in the applicant's file before the credentialing decision. We present all clean file applications to the Chief Medical Officer (CMO) for review and approval. We send applications failing to meet clean file thresholds to the Credentialing Committee for review, further research, and/or a decision.

Credentialing Cycle Time. Nebraska Total Care completes the credentialing process and uploads approved providers in our electronic provider file within 30 calendar days following receipt of a complete application. We include current and newly enrolled provider information in our weekly electronic provider file submitted to MLTC. We send denied applicants written notification with a description of their appeal rights. To accommodate periods of heavy demand, such as before and immediately following implementation, the Credentialing department uses supplementary staff typically dedicated to other markets. Centene has agreements with a Centralized Credentialing Verification Service (CCVS) that may be used to assist in handling heavy volumes. We will seek MLTC approval before utilizing a CCVS. The QAPIC monitors key credentialing indicators quarterly to ensure that we are compliant with initial credentialing and recredentialing timelines. We recredential all providers at a minimum of every 36 months and send recredentialing notices to providers 90, 60, and 30 calendar days before the due date. Our Network team contacts any providers who fail to respond to notifications where there is a potential for recredentialing failure, which would result in network termination.

Acceptance of CAQH Application Submissions. We prefer credentialing applications submitted via the standard CAQH Universal Credentialing DataSource, which simplifies the administrative process for participating providers. Providers may contact CAQH or Nebraska Total Care for assistance with submitting through CAQH. Applications submitted through CAQH are subject to the same review and data verification process as those submitted directly.

Identifying Excluded Providers

We conduct searches on all credentialing and recredentialing applicants and compare them against the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) list of Excluded Individuals/Entities and the System for Award Management, the Social Security Death Master File, and the National Practitioner Data Bank. During initial credentialing, recredentialing, and as part of monthly ongoing monitoring between recredentialing cycles, we consistently monitor providers for loss of licensure, exclusions, fraud and abuse violations, and other sanctions.

Criminal History Checks. Member safety and security are a top priority for Nebraska Total Care. Conducting thorough background checks of our providers is important for ensuring all providers are qualified to treat members. As part of the assessment and reassessment process, and by NCQA requirements, all applicants are required to provide information on any criminal convictions. On an ongoing basis, we monitor for loss of licensure and OIG exclusions, other sanctions, and fraud and abuse violations.

Using Quality and Utilization Measures in the Recredentialing Process

Upon recredentialing, we review member complaints and appeals, utilization management, and quality of care performance. Our Quality Improvement (QI) staff submit detailed logs of complaints, related quality review site visits/results, and corrective action plans, updated regularly. We review annual and/or quarterly profile reports for high-volume Primary Care Providers (PCPs), specialists, and acute care hospitals. Examples of profile measures include:

- **Member Access to Care**: Appointment availability, after-hours access, after hours linguistic access
- **Member Satisfaction**: Member complaints; average months of enrollment
- **Quality**: Quality of care complaints; EPSDT HEDIS measures for 0-15 months, 3-6 years old, and adolescents; outpatient follow-up visits within seven calendar days after an inpatient mental health event discharge
- **Utilization**: ED, outpatient, PCP, specialty office visits/1,000; inpatient admits/1,000; timeliness of screenings; readmission rate; average length of inpatient stay

For providers not identified as high volume, QI and Credentialing staff monitor member and quality of care complaints on an ongoing basis and for the 36 months preceding recredentialing.

Credentialing Committee Review and Decision. Nebraska Total Care's QAPIC has direct responsibility for our credentialing program activities and policies. Our Credentialing Committee reports to the QAPIC, which reports to our Board of Directors. The Credentialing Committee, chaired by the CMO, oversees the credentialing process, evaluates professional conduct, and is responsible for acceptance, deferment, or denial of a provider's application. The Credentialing Committee meets at least monthly, or more often as needed. They are responsible for reviewing monthly reports to measure compliance with credentialing standards.

Credentialing Tribal Providers. Based upon prior guidance from MLTC, we do not require credentialing for Tribal providers and respect their sovereign status with the State of Nebraska. We have a dedicated contract specialist for managing rosters for Tribal providers. To ease administrative burden, we allow Tribal providers to submit their information in formats convenient to them. This has created a more consistent and streamlined process for Tribal providers to update their professional staff and Tribal network.

Ongoing Monitoring. To ensure we comply with all Federal, State, and organizational requirements, we record credentialing activities for all provider types in our Provider Lifecycle System. This is our single relational repository for all our core provider functions, including contracting, credentialing, and data management. Credentialing staff conduct ongoing monitoring and reporting to ensure continued compliance with credentialing timeframes, standards, and policies. Through routine monitoring, our staff verifies that network providers have not incurred exclusions, licensure sanctions, illegal activity, or other negative indicators in between or before their standard recredentialing.

Centralized Credentialing Agencies

We support MLTC's goal to reduce the administrative burden through a centralized credentialing process. Our affiliates have worked closely with Georgia, Illinois, and Texas state partners to implement centralized credentialing by defining and implementing interfaces that effectively transmit authorizations from a centralized portal to MCOs for review and determination. Nebraska Total Care will work with other MCOs and the State to procure the use of a Central Credentialing Verification Subcontractor agency once established in Nebraska. Led by our Chief Executive Officer (CEO), Heath Phillips, who is the President of the Nebraska MCO Association, we have a history of working with the other two MCOs to simplify administrative procedures. This includes working with other MCOs on joint operating efforts in partnership with MLTC to successfully implement the Enhanced Ambulatory Patient Grouping reimbursement methodology with 3M, Navigant, and Optum. We look forward to applying our Nebraska MCO experience in partnering with other awarded MCOs to reduce the administrative burden of centralized credentialing.

We use a multi-pronged approach to educate providers about the credentialing and recredentialing process. First, we post a link to the NCQA CCVS process on our website for providers who may not be contracted with our health plan. Our Contracting and Network Development team informs providers interested in joining our health plan about the steps involved in the credentialing process and how it interfaces with our health plan contracting process. Once providers become part of our network, we educate them regarding recredentialing through our initial provider orientation and our Provider Handbook. This education includes the process of adding a new provider or new location to a provider group already contracted with our health plan. Finally, our Provider Relations team assists network providers as they learn the process and complete recredentialing.

Nebraska Total Care proposes to assign a single point of contact from our health plan to liaise with the CVO. The liaison will answer questions from the CCVS and pass on feedback from providers to the CCVS regarding the credentialing process. We will partner with the CCVS to ensure we can track/view the status of provider applications and share this information with provider partners to support a seamless partnership. support the timely contracting of providers following the completion of the credentialing process by the CCVS, we will request that providers sign the Provider Agreement before the credentialing process completion. Once we are notified by Heritage Health or the CCVS that the credentialing process is complete and we receive the file containing the provider's credentialing approval, we will notify the provider within seven calendar days regarding approval or denial of their contract request. Upon completing credentialing through the CCVS, we will execute the Provider Agreement.

After the Provider Agreement has been fully executed, we immediately load the provider's information into our Provider Lifecycle System and complete the contracting process within 30 calendar days from the date of notification from Heritage Health. Data in our ***Provider Lifecycle System*** flows to downstream systems, including our Find-a-Provider tool, for near real-time updates that are critical for Nebraska Total Care members.

40. Explain the process the Bidder will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing state and federal identification numbers to ensure excluded providers are identified.
Page Limit: 2

Provider File Process Supporting Provider Payment

Nebraska Total Care receives all required data for the provider file from MLTC via a file transfer at regularly scheduled intervals determined by MLTC. Upon receipt, we upload it into our ***Provider Lifecycle System***. We maintain provider files with details on each provider sufficient to support timely and accurate provider payment and meet Federal and MLTC reporting requirements. Our Provider Lifecycle System is an integrated component of our Management Information System (MIS), which supports the entire lifecycle of critical provider operational areas.

Ensuring Sufficient Information to Support Provider Payment. As part of the provider contracting process, our Network Management team collects, and our Provider Data Management (PDM) team enters, a provider's demographic, specialty, location, affiliation, and related information in our Provider Lifecycle System, ensuring that all provider data comes from one governing source for complete data integrity. This information includes provider name, group name, W-9 form showing legal entity name and tax identification number, taxonomy code, address, effective date, end date, primary specialty, Medicaid identification number, payment information, NPI, and licensing/credentialing information, including the DEA license and CLIA certificate as indicated. The provider's financial affiliation(s), license status, specialty/practice type, and pay class (including the provider's contractual relationship with us) support our claims payment processes. We add the provider data to support payment and reporting for services obtained from an out-of-network provider who is not in our Provider Lifecycle System. We perform reconciliation with CMS's NPPES to ensure the accuracy of NPIs and use MLTC's provider data file for validation of Medicaid identification numbers.

Provider Data Integration in Our MIS. Our Provider Lifecycle System is an integrated component of our MIS supporting automated electronic data exchange between our system components, including our Claims Processing System, Customer Relationship Management platform (CRM), and ***Centelligence*** reporting and analytics platform. Provider data is audited and reconciled in our Provider Lifecycle System before distribution to other systems to ensure data consistency and integrity throughout our operations. Our Provider Lifecycle System supports external provider data exchanges with:

- Third-party vendors and Subcontractors for claims, encounters, authorization, and Care Management
- State/other government processes for reporting and provider/member data transmissions between entities
- CAQH, Federal, and State provider databases for provider credentialing and recredentialing purposes

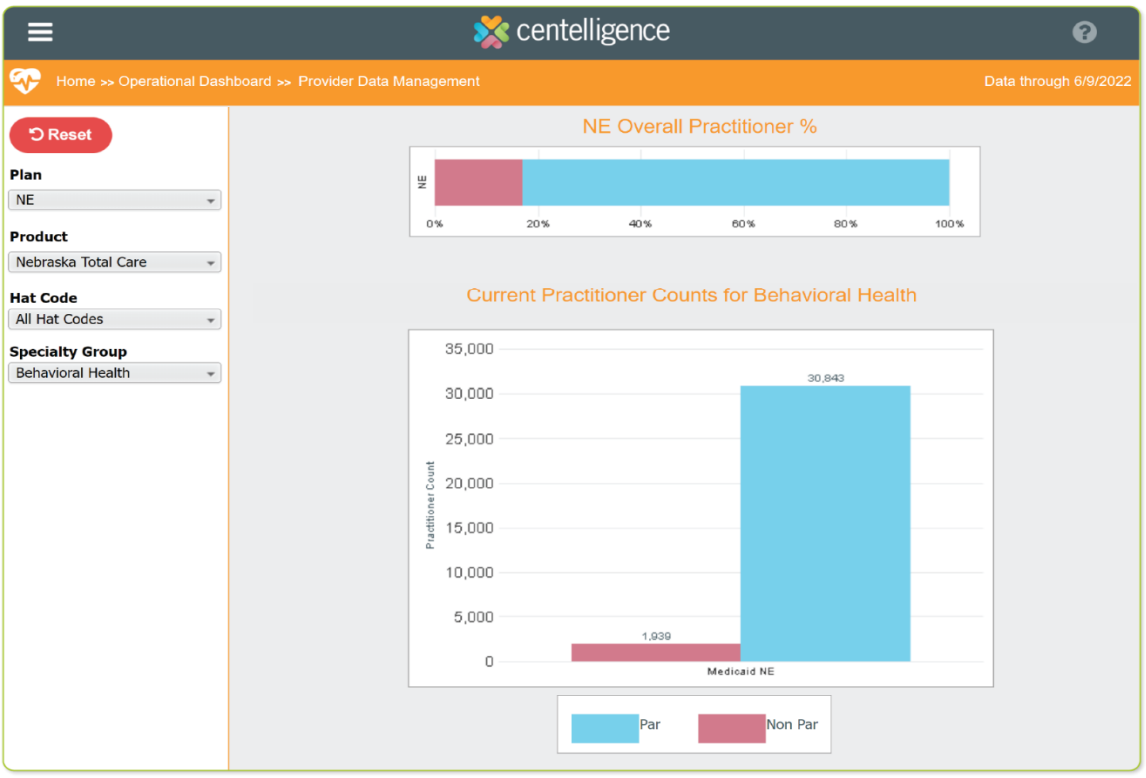
Issuance of 1099 forms. By January 31st of each year, as required by Federal law, our Finance Department issues 1099 forms for all providers (in and out-of-network) who received claims payments of $600 or more in the previous year. We review and validate the accuracy of our provider files at regular intervals throughout the year to expedite the issuance of 1099s in January. Our Nebraska-based Chief Financial Officer and Vice President of Finance ensure accuracy and oversee the proper issuance of 1099 forms by January 31st of each year. Providers do not need to complete any forms for us to issue 1099s. If providers have questions, they can contact the Provider Services Call Center or reach out to their local Provider Relations Representative.

Meeting MLTC and Federal Reporting Requirements. We work collaboratively to meet all MLTC and Federal reporting requirements outlined in the Contract related to provider information and provider network statistics. Our experience and strong relationships with providers, supported by our Provider Relations team, ensure that we maintain up-to-date provider data in our systems to maximize the value and reliability of our payment and reporting processes. We require Subcontractors to verify and report network and utilization information to ensure our compliance with Federal and MLTC reporting requirements.

Our Centelligence reporting and analytics platform includes a full suite of tools, including desktop reporting and key performance indicator (KPI) dashboard capabilities. Centelligence reports on all data sets required for Federal, State, and MLTC reporting, including those related to provider data, 1099 reporting, HEDIS, EPSDT services, and claims timeliness. For example, we use the following reports to monitor and manage provider information:

- **Provider Data Management Dashboard.** Our Network Management staff review the ***Provider Data Management Dashboard,*** sample in **Figure 40.A.**, which is updated weekly to enable continuous monitoring of the administration and management of provider data. The dashboard measures the volume of and success in completing quality management processes relating to provider claims and service activities.

Figure 40.A Example Provider Dashboard.



- **Data and Reports Supporting Our Provider Relations Team.** Our Provider Relations staff use data, analytics, and reports to track various activities, including the trending of issues impacting claims, encounter data, and reports. We document, maintain, and track all claims issues and communication with providers, including any provider issues received from the Provider Services Call Center. For example, if we identify a provider claims issue, our Provider Relations Representative uses contextual documentation and reporting from Centelligence, sourced from our Claims Processing System to solve their issue in real-time. Our PDM team enters and updates provider demographic information from multiple communication sources in our Provider Lifecycle System, ensuring all provider data comes from one governing source and ensuring correct outcomes in areas such as claims adjudication, authorizations, and 1099 forms, and our provider directory listings.

Processes for Cross-Referencing State and Federal Exclusions Lists. Per our policies, providers who do not have a Nebraska Medicaid ID number or have a revoked/suspended Medicaid/Medicare ID number are not eligible for payment from our health plan and are suppressed from our online provider directory tool, ***Find-a-Provider***. Our Provider Lifecycle System is configured to prevent entering a provider record unless the Nebraska Medicaid ID number is provided. This enables our ***Provider Lifecycle System's Sanction Pay Class mechanism*** to ensure no provider on an exclusion list is eligible for payment. Upon notification from MLTC that a provider has been sanctioned, we will notify the provider via certified mail and verify with MLTC that we will not pay claims to the sanctioned provider. We report provider network statistics, including excluded providers, to MLTC monthly and ad-hoc.

Provider Data Collection/Validation Process. We will collaborate with the credentialing verification organization to confirm providers have valid information to be credentialed and/or recredentialed as Nebraska providers. Between credentialing and recredentialing cycles, we query the US Department of Health and Human Services OIG's List of Excluded Individuals and Entities Database and MLTC's Excluded Provider Listings monthly. If we find providers in either database, we notify our Vice President of Population Health and Clinical Operations and our Compliance Officer. The Compliance Officer notifies MLTC, and we immediately suspend the provider from the network. We recoup any claims paid to the provider during the exclusion period.

Preventing Payment to Excluded Providers. Our Claims Processing System contains adjudication logic that prevents claims from advancing to payment status for providers found to have Federal or State exclusion status. The system flags provider records so that claims from excluded providers will automatically deny, supporting the other controls described above. The remittance contains a detailed explanation indicating the denial reason, which is available to providers via phone, fax, and through our secure Provider Portal.

RFP 112209 O3

Attachment B.33

Network Development Plan

Attachment B.33 Network Development Plan

Network Development Plan

Nebraska Total Care's current provider network includes all provider types in every area of the state and key bordering state communities. Through a broad provider network and frequent member contacts and education, we expect improved outcomes and lower costs through competitive contracts and the reduction of unnecessary out-of-network services. We consider a variety of factors in our network development and management plan including, but not limited to, current and future membership, utilization and service needs, contracted providers and specialty providers that are needed and available, capacity within the provider network, open and closed PCP panels, and geographic access requirements.

The access standards for the new Scope of Work, as outlined within **Attachment 14**, are similar to the accessibility standards under our current Heritage Health contract, except for the addition of the Dental benefits program and related provider access requirements. Nebraska Total Care will partner with our affiliate, Envolve Dental, to enhance the existing Nebraska dental network in place for our HIDE SNP Plan that has been in place since January of 2022. This will allow for a seamless transition for members to begin receiving Dental services covered by Nebraska Total Care as a further integrated benefits plan under Heritage Health.

Nebraska Total Care will continue to monitor its provider network to ensure all members have equitable access to covered benefits while expanding its dental network, as shown in the summary timeline. Nebraska Total Care's specific network monitoring and development activities are described in detail in **Table 33.A and 33.B**.

Figure 33.A Provider Network

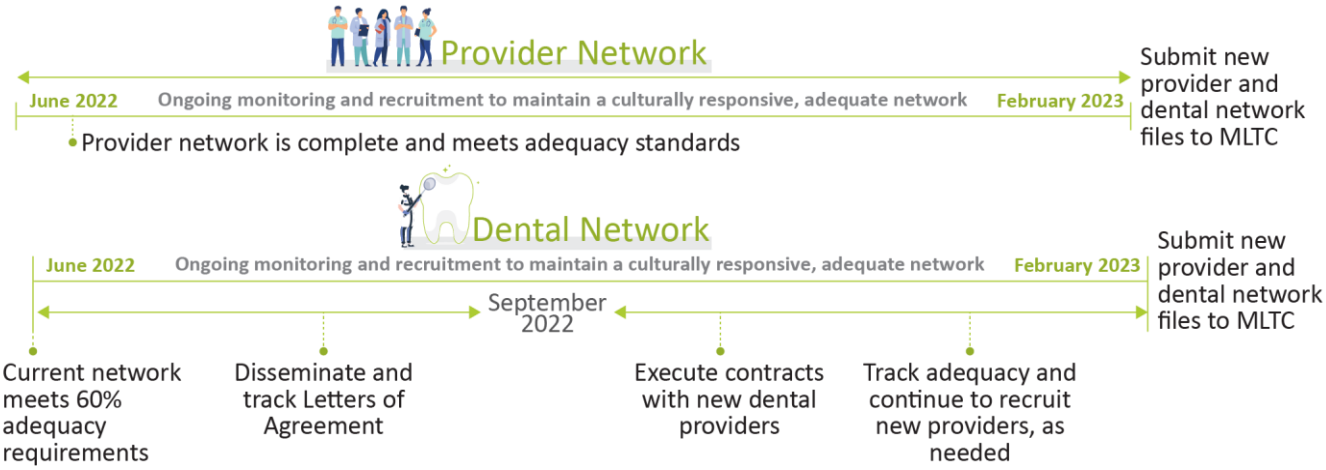


Table 33.A Timeline for Network Maintenance to Ensure Continued Adequacy

Network Development/Maintenance Task	Target Completion Date/ Frequency
Our network meets 100% Adequacy requirements for PCPs, specialists, hospitals, and ancillary services at RFP submission.	Completed
Analyze provider network adequacy by running GeoAccess maps for all contracted Primary Care Providers, Pediatricians, Internal Medicine, OB/GYN, Physician Assistants, and Nurse Practitioners), High Volume Specialists, Behavioral Health providers, Pharmacy providers, key ancillary services, and Hospitals.	Completed, Monitored, and Reported Quarterly
Monitor provider enrollment files, outreach to contracted groups to complete credentialing, and enrollment for new providers.	Daily reporting
Out-of-Network provider review during our Single Case Agreement Workgroup.	Weekly
Proactive border State contracting efforts and outreach	Ongoing

Network Development/Maintenance Task	Target Completion Date/ Frequency
Continually assess the availability of practitioners to include numbers, geographic location, and cultural diversity and analyze performance against the standards.	Quarterly Health Equity and Access Reviews
Submit new contract provider network files to MLTC.	2/28/2023

Table 33.B Timeline for Dental Network Development

Dental Network Development Task	Start Date	End Date
The dental network meets 60% adequacy requirements.	Complete	
Disseminate Letters of Agreement to dental providers (including Endodontists, Oral Surgeons, Orthodontists, Pedodontists, Periodontists, and Prosthodontists) and track responses.	5/1/2022	9/30/2022
Contact non-participating dental providers to encourage network participation.	5/1/2022	2/28/2023
Execute contracts with new dental providers (including Endodontists, Oral Surgeons, Orthodontists, Pedodontists, Periodontists, and Prosthodontists).	9/1/2022	12/31/2022
Monitor and track progress toward network adequacy.	Monthly as of 5/1/2022	
Submit dental provider network files to MLTC demonstrating network adequacy.	2/28/2023	

Utilizing Value-Based Purchasing (VBP) to Enhance Network Access

Nebraska Total Care utilizes a multi-pronged value proposition to attract and retain its target network providers. This approach centers on a portfolio of tools to address each provider's specific needs. Contracted providers, upon both parties' agreement, will follow the Value-Based Purchasing continuum from fee-for-service to Pay-for-Performance, to shared savings, to downside risk value-based contracts. These tools include:

- Sharing analytic tools to give providers actionable data to improve quality and lower costs.
- Making the tools available easily accessible via our Provider Portal and other secure modes of passing data.
- Contracts are designed to incentivize high quality and efficiency, rewarding providers that outperform to achieve quality targets.
- Accurate, timely, and simplified payment processes centering on the use of national EDI clearinghouses for claims submission, online clean claims submission tools, claims status inquiry tools, electronic funds transfer, and expedited claims processing for network providers.
- Streamlined administrative functions as demonstrated by the paperless referral process, multiple entry points for authorizations (online, fax, and phone), and simplified prior authorization process.
- Physician practice management tools: provider-tested and driven medical home strategies and integrated delivery system tools augmented with Centene resources to assist the provider in accomplishing their objectives.
- Value added resources and processes to enhance member compliance: These vary based upon product qualification, examples include My Health Pays Rewards Program, ConnectionsPlus, Start Smart for Your Baby, and Breast Pumps.

Table 33.C outlines Value-Based Purchasing (VBP) models available to Nebraska Total Care providers.

Table 33.C: VBP Models Encourage Provider Participation and Drive Quality

QualityPATH Premier (LAN Category 4 – Capitation+Shared Risk)		
Upside & Downside Risk & PCP Capitation (Model 1)	• PMPM reimbursement for the cost of care for assigned TANF members. • Providers share in the savings they generate due to engaging members in preventive care, reducing the instances of potentially preventable events, and managing complex members towards better 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)		

QualityPATH Premier (LAN Category 4 – Capitation+Shared Risk)		
Total Cost of Care	• Providers share in the savings they generate due to engaging members in preventive care, reducing the instances of potentially preventable events, and managing members via case management and care coordination. • 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))		
Equity-Based Contracting (new)	• Providers earn incentives for increasing HEDIS rates for specific populations with identified health disparities. • We are piloting the 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. • Based on initial program results, we will consider adding an incentive for providers to refer members to community-based organizations and document referrals in Findhelp to complete a closed-loop referral.	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 the savings they generate due to engaging members in preventive care, reducing the instances of potentially preventable events, and managing members via case management and care coordination. • 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 who have 50 or more 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 member outreach in the program, and providers more than doubled their program earnings year over year.***	All PCP offices, regardless of 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, and 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

QualityPATH Premier (LAN Category 4 – Capitation+Shared Risk)		

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/GYN

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

Continuous Network Enhancements

Nebraska Total Care's Network Management and Contracting team enhances the existing provider network by continuing to negotiate and execute Nebraska Medicaid-approved provider agreements. Any perceived network gap reported by a member or provider will be investigated. When there is an available provider to fill the gap, Network Management staff will outreach to provide a proposal to join our network. Nebraska Total Care is enhancing its provider network using the following strategies.

Recruiting Specialists. We continually enhance our specialist network to meet the needs of our member population.

- Nebraska Total Care has worked with other out-of-state hospital systems to enter into agreements that include their specialty networks
- Nebraska Total Care has worked with large independent provider organizations to incorporate their specialty networks into Nebraska Total Care's provider network
- Nebraska Total Care is targeting all specialists listed on the State Medicaid provider list who are designated as "active" and more specifically those identified by Nebraska Medicaid as newly enrolled Nebraska Medicaid providers

Contracting with Hospitals. All Nebraska hospitals are contracted with Nebraska Total Care. Nebraska Total Care's targeted hospital network was developed based on service and access requirements outlined by the State. Nebraska Total Care is committed to maintaining a provider network that supplies sufficient access to short-term acute, tertiary, rehab, children's, and Critical Access Hospitals services. Nebraska Total Care works with local specialty hospitals to identify the most frequent out-of-state referrals and attempts to contract with the out-of-state receiving facility.

Contracting with Other Service Providers. Nebraska Total Care shall ensure the availability of medical service providers including, but not limited to, therapy, durable medical equipment, orthotics, prosthetics, telehealth, non-emergent medical transportation, pharmacy, radiology, dental, and laboratories. All services must be provided following applicable State and Federal laws and regulations.

Expanding Primary Care Through Telehealth. Virtual PCP Program. We are piloting the Babylon 360 Virtual PCP program (Babylon 360), an innovative program to address member Social Determinants of Health (SDOH) barriers and health disparities, increase access, and advance health equity. Through this model, we can identify members with low primary care utilization and support them via telehealth PCP services. Our Care Management team and Babylon's Care Advisor work together to provide Care Coordination and educate members on benefits, resources, and Care Management programs.

Building Dental Provider Network. Envolve Dental continues to outreach dental providers to maintain a strong dental provider network and establish solid partnerships with providers. We manage an "any willing provider" network that includes FQHCs, RHCs, and large dental service organizations, along with private practice dentists. Our network development strategy begins with stakeholder engagement and an understanding of the local community. Our network team meets with the Nebraska Dental Association, Health Center Association of Nebraska, and other thought leaders to remain relevant in the community and informed of its needs.

Rural Providers. Our long-term strategies aim to expand network capacity in all regions, including rural and frontier areas, to improve members' access to care. Investments to increase member access to care include:

- PROJECT ACCESS. Centene and Nebraska Total Care are partnering with The Health Center Association of Nebraska (HCAN) to establish PROJECT ACCESS. Our partnership focuses on increasing member access to care via FQHCs through competitive compensation, improved clinic operations, and increased capacity.

- PROJECT ACCESS includes:
  - Recruitment funds to assist FQHCs in offering more competitive compensation packages through incentives such as sign-on bonuses, loan forgiveness, continuing education, licensure expenses, and/or relocation assistance.
  - Clinical optimization funds for FQHCs to improve operational processes for member scheduling and throughput. Funds can be used for hiring consultants to review processes or upgrading technology.
  - A capital request process to increase access by adding physical capacity to attract employees to FQHCs. The steering committee will seek out other community stakeholders in the education and health care fields, such as universities, colleges, and trade associations.

Monitoring Provider Enrollment File. Nebraska Total Care will continue to review new additions to the provider enrollment file received from Nebraska Medicaid. We will outreach to contracted groups to request revised rosters, so credentialing and enrollment of new providers can be completed. When new solo practitioners or groups are identified on the enrollment file, our team will outreach to provide a proposal to join our network. Nebraska Total Care will also work with provider partners to assist in identifying underserved specialty needs and support recruiting efforts, when possible.

Leveraging Feedback from Stakeholders. Participation in Nebraska Total Care's network development process occurs through many means. Those means include but are not limited to, Provider Services calls, Member Services calls, Provider Relations meetings and outreaches, Member Advisory Committee meetings, Provider Advisory Committee meetings, and member and provider requests received through the Nebraska Total Care website.

Continuous Monitoring for Network Improvement Opportunities

At least annually, Nebraska Total Care will assess the availability of practitioners within its delivery system to include numbers, geographic location, and cultural diversity and analyze performance against the standards as defined below. Data sources may include but are not limited to:

- Self-reported member data such as satisfaction survey results.
- GeoAccess reporting
- Provider panel status
- Complaints/grievances regarding concerns with physician availability

Nebraska Total Care shall ensure network providers are available within a reasonable distance to members and accessible within an appropriate timeframe to meet members' health care needs. Nebraska Total Care shall ensure that participating providers are available within the distance requirements set forth by Nebraska Medicaid in the new Scope of Work, Attachment 14.

Gap Analysis and Intervention. Currently, Nebraska Total Care analyzes its provider network adequacy quarterly by running GeoAccess maps for all contracted Primary Care Providers (Pediatricians, Family Practitioners, Internal Medicine, OB/GYN, Physician Assistants, and Nurse Practitioners), High Volume Specialists, Behavioral Health providers, Pharmacy providers, key ancillary services, and Hospitals. With the integration of Dental benefits and access standards, Nebraska Total Care will begin analyzing its provider network adequacy quarterly by running GeoAccess maps for all contracted general dentists, oral surgeons, orthodontists, periodontists, endodontists, prosthodontists, and pedodontists. Nebraska Total Care will provide GeoAccess mapping and coding of all network providers as defined within the State contract and upon an ad hoc basis upon State request. GeoAccess mapping will also be run when there is a significant provider change that may affect adequacy.

At least quarterly, Nebraska Total Care evaluates provider network cultural competency, provider network adequacy, and appointment availability. The assessment is reported to the Quality Assessment and Performance Improvement Committee (QAPIC) at the individual practitioner, physician network, and/or medical group levels and/or as an aggregate as appropriate by provider type at least annually, although interim quarterly reports may also be reported to the QAPIC. The QAPIC, or designated subcommittee, will review the information for opportunities for improvement. Analysis of data will include a comparison of results against the standard and analysis of the causes of any deficiencies if they occur. If data uncovers any provider network deficiencies, including those related to cultural competency, Nebraska Total Care implements the network gap strategy described below.

Immediate, Short-term Interventions. When a network gap occurs and a member needs prompt access to specific services, we implement interventions such as:

- We identify the nearest non-contracted provider and authorize out-of-network (OON) services. Once the authorization is finalized, the Network Management and Contracting team will outreach the OON provider to join our network or minimum agree to a Single Case Agreement.
- If the member requires covered services from a specific provider type or specialty that is not within the travel standard, we will authorize medically necessary covered services by an OON provider until a suitable network provider is

available. Once the authorization is finalized, the Network Management and Contracting team will provide a proposal to become a participating provider.

- Single case agreements will be negotiated by Network Management and Contracting team, and inquiries will be made to determine if the provider is open to a contractual relationship.

Long-term Network Gap Solutions. We implement the following additional recruitment strategies:

- Approach PCPs and other providers with limited or closed panels and request that they open their panels to new members.
- Identify potential providers through sources such as listings from the local medical societies and provider associations, case managers, Community Health Workers, the Provider Advisory Committee, Member Advisory Council, established community relationships, Internet resources, and personal recommendations from network providers in the area.
- Utilize listings of newly licensed providers and State reports of providers issued new Nebraska Medicaid numbers.
- Monitor OON utilization and make outreach to OON providers, as appropriate
- Maintaining relationships and ongoing dialogue with providers who have previously declined to join the provider network.

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B. Technical Approach

V.J Provider Services

V.J Provider Services

41. Provide a description of the Bidder's provider services program/department and how the Bidder intends to partner with the provider community to deliver covered services. Include:
• Information available in the Provider Handbook or other media.
• Description of any committees the Bidder will form for providers to offer input regarding issues such as the Bidder's service delivery, MCO/provider interactions, and potential opportunities/ innovations for improved health outcomes.
• Description of how the Bidder will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP.
• Sample provider outreach methods.
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Nebraska Total Care's Provider Services Program

We deliver a high-quality Medicaid provider experience by connecting our Provider Relations Representatives, Provider Services Call Center, and clinical and Quality Improvement leaders to achieve the same goal: being available and responsive to any concern.

Our Provider Relations (PR) department is responsible for executing our Provider Services program. Our Senior Manager of Provider Relations/Claims Educator, Provider Relations Representatives (PR Representatives), Provider Services Call Center staff, and staff from cross-functional departments such as Quality, Claims, and Utilization Management (UM) work together to support providers. Our entire PR team is based in Nebraska, so we know our providers and the communities they serve.

Provider Relations Representatives. Our staff of nine PR Representatives and one Coordinator are located throughout the State to meet with our providers and build relationships. **Figures 41.A** and **41.B** show our Provider Relations service area maps for Physical Health (PH) and Behavioral Health (BH) providers. These maps are available on our website, along with contact information for the representative assigned to each service area, so provider office staff always know whom they can call or email for any issue. In addition to geography, we assign PR Representatives based on specialties. Our Tribal Liaison has training in different billing procedures and Native American customs and traditions. Other representatives work with providers who serve unique populations (for example, Boys Town and Children's Hospital). Whereas some MCOs have a general inbox or office phone line, Nebraska Total Care assigns individual employees to respond to assigned providers and resolve issues whenever possible. ***Our culture of accountability is one of the reasons provider complaints have decreased by more than 50% annually for the past three years.***

When a provider signs a contract with Nebraska Total Care, a Provider Relations Representative reaches out to supply their contact information and schedule an orientation within 30 days. Providers can call or email their PR Representative with any questions. The most common reasons are complex claims issues, education, payment policy review, or negative balance reporting. We train our PR Representatives on these subjects and others and empower them to resolve inquiries by reaching out to experts within our organization as needed.

Highest Provider Satisfaction Score

According to our 2021 Annual Independent Provider Satisfaction Survey, Nebraska Total Care achieved the highest provider satisfaction score for the third year in a row. Nebraska Total Care is the preferred MCO among Medicaid providers with ***a 63% satisfaction rating, nine percentage points above the nearest competitor, and the highest rating of any MCO since the implementation of Heritage Health managed care.***

"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, President/CEO CenterPointe

Figure 41.A Provider Relations Service Area Map – Physical Health

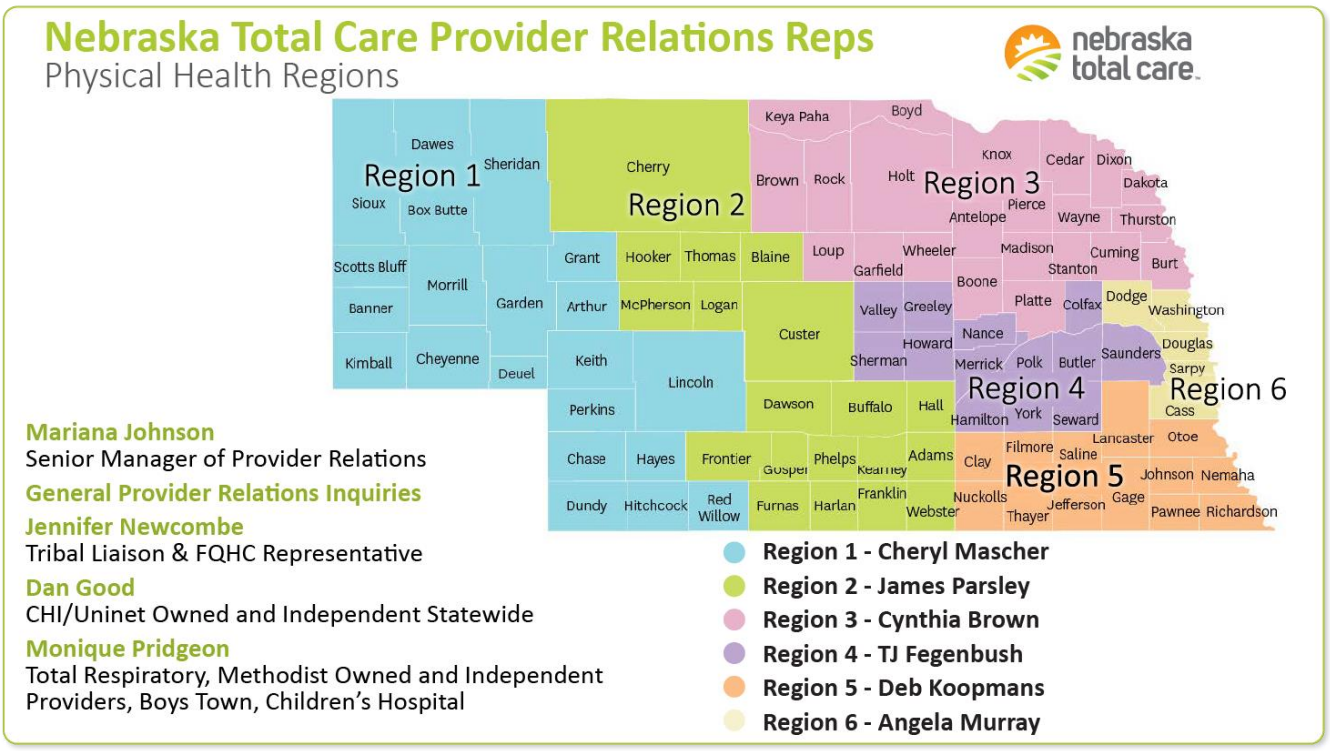
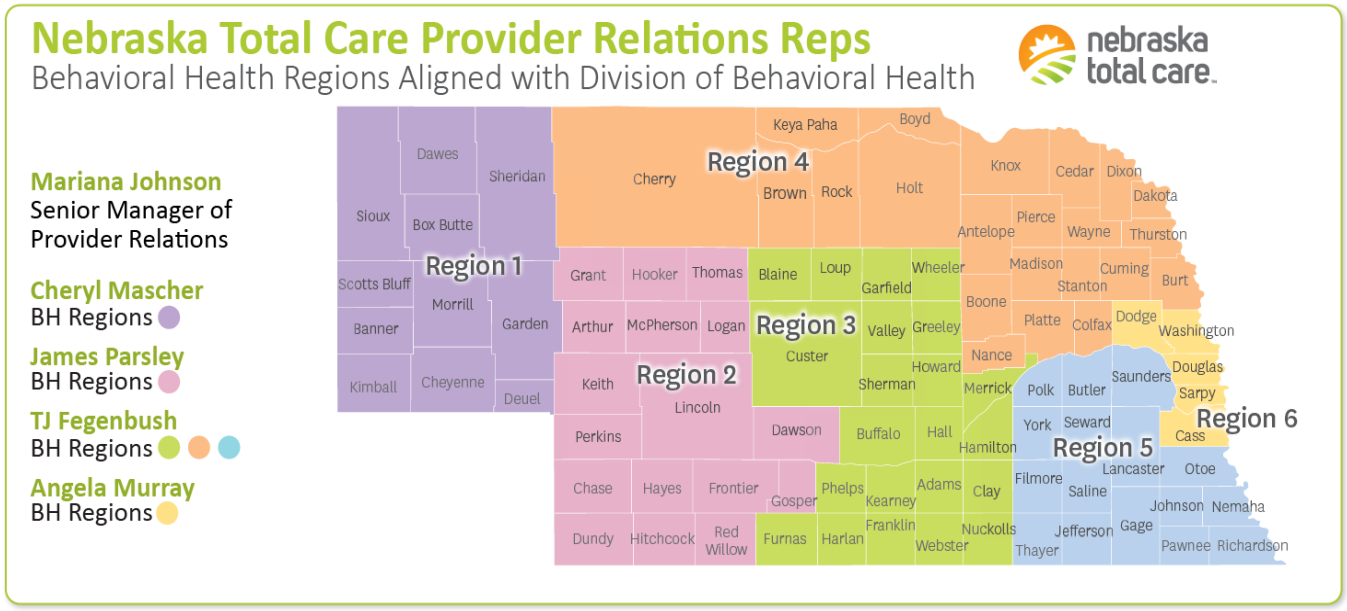


Figure 41.B Provider Relations Service Area Map – Behavioral Health



Quality Practice Advisors. Nebraska Total Care's Strategic Provider Partnership team works exclusively with providers who participate in our Value-Based Purchasing (VBP) program, sharing data and ideas about practice transformation. Our Quality Practice Advisors (QPAs) work with larger VBP groups, providing education and support to ensure they succeed and benefit professionally and financially from our VBP arrangement.

Provider Services Toll-Free Telephone Line. Nebraska Total Care's Provider Service Representatives (PSRs) staff the Call Center from 7:00 a.m. to 8:00 p.m. CST and our clinical pharmacists from 8:00 a.m. to 8:00 p.m. CST Monday through Friday, meeting State contractual requirements. As a value added service, our Nurse Advice Line (NAL) is available 24/7 for providers who have urgent care questions or authorization needs.

The Provider Services team and the field-based Provider Relations Representatives share a Customer Relationship Management (CRM) platform. They can contact each other to discuss provider concerns and route work to one another. PR

Representatives and PSRs enter notes from provider interactions into the shared system, and both can find background information quickly to inform follow-up contacts. We believe that providers should never face a situation where they must repeat their explanation of a problem to multiple people. Managers of the Provider Relations team and the Call Center meet weekly to resolve existing issues and review data that might indicate concerning trends.

Information in the Provider Handbook and Other Media

Nebraska Total Care continuously seeks input from providers to inform our approach, material and education development, and service delivery. This strengthens our relationships with the provider community, promoting the delivery of high-value care and advancing health outcomes. When providers join Nebraska Total Care, we notify them during orientation that they have access to the online Provider Handbook and supplemental materials and can request a hard copy at no charge. We update the Provider Handbook at least twice each year based on input from providers, MLTC, and our staff; or to reflect policy and procedure changes. We alert providers of updates through a provider news web posting and distribution via our biweekly email Newsletter. The Provider Handbook addresses, at a minimum, topics required in the Scope of Work, Section J.3. For the new contract, we will submit the Provider Handbook for MLTC review and approval a minimum of 90 days before implementation. For updates, we will submit for MLTC review and approval 60 days before implementation and make the new Provider Handbook available to providers within ten days of receiving MLTC approval. Topics include but are not limited to:

- Description of Nebraska Total Care and Centene
- Services and benefits
- Emergency service responsibilities
- Confidentiality provisions
- Process for verifying a member's enrollment with Nebraska Total Care
- Medical necessity standards as defined by MLTC and Nebraska Total Care
- Practice guidelines and protocols
- Provider credentialing process and criteria
- Medical record standards
- MLTC standards for geographic access and appointment availability
- Mainstreaming requirements
- UM requirements
- Clinical criteria for admission, continued stay, and discharge
- Reporting requirements for serious reportable events and reportable adverse incidents
- Compound prescription requirements
- Prospective drug utilization review response requirements
- Pharmacy payer sheet
- Use of MLTC preferred drug list
- Paper and electronic claims submission protocols and standards
- Policies and procedures provider complaint system
- Policies and procedures for grievance system, including how to file a grievance or appeal on a member's behalf with written permission
- Process for appealing payment and service denial decisions
- Procedures for using web-based provider services
- Call Center numbers and hours
- Names and contact information of Provider Relations staff
- MCO prompt pay requirements
- Information regarding Nebraska Total Care's chronic care and disease management programs and instructions for making referrals
- Quality performance standards and requirements
- Expectations for PCPs
- Provider rights and responsibilities

Additional Materials. The Provider Billing Manual is Nebraska Total Care's guide that describes how providers are expected to bill for services covered by our program. The Provider Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements. Our provider quick reference guide summarizes billing requirements and operational policies and procedures that govern our program. Clinical Practice Guidelines (CPGs) and related educational materials are available on our website and in printed form upon request. Examples of conditions for which we provide CPGs include but are not limited to adult and pediatric preventive care, asthma, diabetes, sickle cell, congestive heart failure, bipolar disorder, major depressive disorder, and schizophrenia. Throughout the life of the contract, we regularly post and share guidance and education through the public website, email, and hard copy as needed. We detail the full range of these communications in our response to Question V.J 43.

Formal and Informal Communications. We use our public website to regularly post provider news items and sign up for our email distribution list. We distribute bi-weekly Provider Newsletters, formal quarterly Provider Newsletters, and have a provider resources area for quick reference guides and training alerts. Our Provider Relations Representatives make regular site visits to provider offices and are always a phone call or email away.

From 2019 to 2021, our ratio of calls to the Provider Services line dropped by more than 33%, from 6.0 provider calls per 100 members to 3.9. This decline is a direct result of our proactive communications and our cross-departmental efforts to give providers a better understanding of our policies and procedures and guidance on accessing information and

functionality via our public website and secure Provider Portal.

Committees Give Providers Formal Means to Offer Input

Nebraska Total Care has a comprehensive committee structure that includes providers as integral participants. Through our structure, we solicit their input on services, member interactions, opportunities for improvement, and innovations. The Provider Advisory Committee (PAC), the Behavioral Health Advisory Committee, and the Tribal Health Advisory Committee meet quarterly. The Clinical Advisory Committee, which focuses on improving care solutions, informs our services.
We implement process and program improvements based on feedback gleaned during committee meetings. For example, in response to concerns from the PAC about the post-pay review process, we streamlined the process for our therapy authorizations, improving member access. We expanded administrative authorizations to include 12 PT/OT/ST sessions annually per discipline for all members needing this service. We configured our system to automate this authorization, eliminating the burden on members and providers to submit requests and wait for approval processing. For a complete description of how the PAC helped enact this improvement and an overview of our committee reporting structure, see our response to Question V.J.44.

"Nebraska Total Care's pre-authorization system is user-friendly and they are more than willing complete education and put the patient first at all times. They have recently accepted that 12 physical therapy visits are allowed without authorization. This is a very patient-first mentality and is very much appreciated. It is also very much respected that their pre-authorization system exists in-house. In other words, they do not use a 3rd-party company. When there is an issue with an authorization, Nebraska Total Care's staff is extremely helpful, readily available, and consistently willing to do what is best for the patient."

-Brian Brunken, Board-Certified Clinical Specialist in Orthopedic PT, Practice Management Committee Chairperson

Provider Advisory Committee (PAC) Representation. Nebraska Total Care has an established PAC in full compliance with SOW Section J.5.e. We recruit participants to our PAC and review the composition annually to ensure adequate representation of Nebraska's population, including geography, race/ethnicity, and members' health concerns. We invite larger systems and independent providers, including representatives from specialists in BH, pharmacy, and those serving individuals with disabilities. **Table 41.A** lists the Nebraska health care leaders on our Provider Advisory Committee.

Table 41.A Nebraska Total Care Provider Advisory Committee

Name	Affiliation
Brian Brunken	PT/OTS, Go Physical Therapy/Nebraska Physical Therapy Association
Jessica Thoene	M.S. CCC-SLP, Alpha Rehabilitation/Nebraska Speech-Language-Hearing Association
Kendra Brummund	Office Manager, Central Nebraska Rehab Services
Mark Stortvedt	Ph.D., LIMHP, CPC – Executive Director, Oasis Counseling International
Sara Ellis	Patient Accounts Director, York
Megan Reay	LIMHP, LPC, NCC – Vice President/Quality Performance Improvement, Omni Inventive Care
Amy McMurtry	PharmD – Retail/Specialty Manager, Nebraska Medicine-Durham Outpatient Center Pharmacy
Staci Hubert	RPh – Pharmacist/Owner, Ashland Pharmacy
Candice Mullendore	MS, OTR/L, Pediatric Physical Therapy
Mike O'Dell	CFO, Box Butte General Hospital

For a description of how we use PAC feedback to improve our service, see our response to Question V.J.44.

Sample Provider Outreach Methods

Nebraska Total Care's provider outreach strategy extends from our PR Representatives, who conduct orientations and office site visits and communicate regularly with providers throughout our organization, up to and including Plan President and CEO Heath Phillips. We participate in more than 40 public events yearly. When attending these events, our staff offer educational materials and have computers to sign up providers for newsletter distribution and offer quick tutorials on accessing the secure Provider Portal and website navigation. We participated in the following public events in March 2022:

- **NHA Advocacy Day (March 2).** CEO Heath Phillips and Tim Easton, our Senior Director of Network Development and Provider Services Manager, attended this workshop with hospital CEOs, legislators, DHHS, and health care advocates.
- **Provider Advisory Committee (March 10).** Adam Proctor, our Senior VP of Operations/COO, led the quarterly meeting.
- **Behavioral Health Advisory Committee (March 11).** Mariana Johnson, our Senior Manager of Provider Relations, led this group's quarterly meeting.
- **Brain Injury Alliance of Nebraska Conference (March 17-18).** James Parsley from our Provider Relations team attended this conference, which was virtual due to the COVID-19 Public Health Emergency (PHE). Nebraska Total Care attends the conference annually.

- **Kearney Town Hall (March 30).** Tim Easton and Mariana Johnson led this community forum via webinar. We will offer Town Halls in person throughout the State as we have historically, and we will continue to offer the virtual Town Hall option that we added during the COVID-19 PHE.
- **NABHO Conference (March 30-31).** Tim Easton, Adam Proctor, and Provider Relations Representative Angela Murray attended this two-day conference for State BH providers.

Through all these touchpoints, regular written communications, and our provider website, we create a culture of openness that lets providers know we are there to support their mission of providing high-quality care to Nebraskans.

42. Describe the Bidder's additional pathways for Provider Services including chat functionality, email communication, and other electronic communication methods.
Describe the Bidder's Provider Services toll-free telephone line, including:
• How the Bidder will provide a fully staffed line between the hours of 7:00 AM and 8:00 PM, Central Time. Monday through Friday, to address non-emergency issues and how the Bidder will provide a clinical pharmacist staffed at all times during the hours of 8:00 AM and 8:00 PM, Central Time, Monday through Friday.
• How the Bidder will ensure that provider calls are acknowledged and resolved within three business days of receipt.
• The location of operations, and if out of state, describe how the Bidder will accommodate services for Nebraska.
• How the Bidder will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction.
Page Limit: 3

Nebraska Total Care's Provider Services toll-free telephone line leverages optimal technology and human resources management to give the provider community the highest level of service. We are moving beyond traditional modes of communication by offering chat functionality, email communication, and secure messaging through our Provider Portal.

Leading Innovation and Best Practices

Provider Services Toll-Free Telephone Line

Providers can speak to a live person through the toll-free Call Center any time day or night. PSRs staff our toll-free Provider Services line Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time. For provider calls received after hours or on State-designated holidays, providers can speak with representatives from our 24-hour Nurse Advice Line (NAL) to coordinate emergency prior authorization (PA) requests and discuss urgent or emergent member issues with a Registered Nurse. We ensure a Clinical Pharmacist is available to take pharmacy-related calls between 8:00 a.m. and 8:00 p.m. Central Time, Monday through Friday. Providers who would like to speak with a Clinical Pharmacist can select that option through the Interactive Voice Response (IVR), or PSRs can warm transfer a provider to a pharmacist. **Table 42.A** shows that our 2021 performance exceeded Nebraska's standards.

Table 42.A Provider Services Line 2021 Performance Metrics

Category	State Requirement	Nebraska Total Care Performance	Met Standard?
% answered within 30 seconds	90%	93.9%	Yes
Average speed of Answer	30 seconds	11 seconds	Yes
Abandonment rate	<5%	1.0%	Yes

Our Provider Services Call Center offers premium technology and resources. Our PSRs have all the information they need to assist providers through our Customer Relationship Management (CRM) platform. The CRM connects member, provider, State, and financial data in real-time for PSRs, using our integrated MIS.

Providers can use the IVR system to enter their NPI and Tax ID combinations as identifiers. Our Computer Telephone Integration technology matches providers with an appropriate PSR based on this information. Providers can use the self-service option to check claim status without the assistance of a PSR.

We train our PSRs to answer inquiries across all products, programs, and populations in Nebraska. We empower them to resolve provider issues during the provider's first call. We provide seamless Provider Services Call Center operations for PH, BH, vision, and pharmacy. As the State adds dental services to Medicaid managed care, we will offer dental services through our affiliate, Envolve Dental, Inc.

Improving Access to Dental Care

Nebraska Total Care uses the innovative IEX Workforce Management System to create a responsive, scalable Call Center that ensures we meet or exceed MLTC requirements. Based on years of call data, IEX factors in historical call duration, call patterns, seasonal variations, and program features to adjust staffing. These capabilities enable us, for example, to accommodate longer call times for providers who are new to managed care. Our IEX model accounts for variations in call-type complexity, allowing us to create better service performance to standards than using static PSR-to-provider ratios. This predictive modeling capability allows us to forecast staffing needs and maintain standards, adjusting for both the size and type of membership and size of the network, even during rapidly changing situations, such as open enrollment and network expansion.

Predictive modeling guides our staffing and workflow distribution. Our Call Center's Workforce Analyst monitors real-time call activity (calls in queue, average speed of answer, percentage of calls answered within 30 seconds, call abandonment rate, hold times, and blocked call rate) via an online dashboard. Upon detecting an increase in call volume, the Workforce Analyst immediately initiates redistribution of staff among queues to ensure adequate coverage. As an added layer of

customer service, the Call Center Director and Quality Specialists/Supervisors have access to real-time activity dashboards, ensuring that all eyes are attentive to call volume status, enabling us to make staffing adjustments as needed, ensuring appropriate coverage, and identifying any trends of increased call volume.

Ensuring Calls are Acknowledged and Resolved Within Three Business Days

Nebraska Total Care strives for first-call resolution on all calls. When a provider has an issue that requires more attention, we rely on our team of provider PSRs. To become a PSR, an employee must serve for at least six months as a Member Services Representative, achieve excellence through a Call Quality Audit score of at least 95%, and undergo the advanced provider PSR training. PSRs learn to educate providers and their staff on referral and claims payment procedures, claims disputes, eligibility verification, covered services, authorizations, the provider complaint system, and a broad range of other topics. PSRs can access Nebraska's online Medicaid eligibility verification portal from an icon on their integrated desktop to verify member eligibility.

Our PSR marks the item as unresolved in our CRM's Provider Relations work basket for issues not resolved on the first call. Our Provider Relations team monitors this inbox and sends follow-up responses to providers daily. The provider's assigned Provider Relations Representative takes the lead in resolving the issue within three days. If we cannot resolve the issue within three days, we notify the provider of the expected timeframe for resolution, which will not exceed 30 business days, including referrals from MLTC. Integrating the Call Center and Provider Relations team enables us to achieve resolution in a more timely and convenient manner for providers.

Location of Operations

The core of our PSR operations are based in Nebraska. During the pandemic, our call center transitioned to remote, which continues to provide efficiencies and flexibility that we have maintained. The majority of our PSRs remain in the State of Nebraska. To maximize efficiency and maintain operations during extreme weather or unforeseen service disruption, we can distribute calls across the Centene enterprise Call Center workforce. PSRs from out of state who handle Nebraska calls are cross-trained on Heritage Health's benefits packages, policies, and procedures and have access to the CRM and IEX.

Measuring and Monitoring Response Accuracy

Our Call Center management team continuously reviews PSR and department-level performance to measure compliance with required performance standards, the accuracy of responses, and caller satisfaction. Data from our integrated MIS feeds into our CRM system. Using the toolbox of fully customizable reports available in our CRM system allows Call Center management to monitor and track overall department performance, including PSR accuracy; operational metric results; staff performance; queue aging; frequent callers; and call types, routing statistics, and volumes. Our management team can drill down into performance dashboards to the PSR level and monitor daily, weekly, and monthly performance compliance trends. These tools help management forecast staffing needs and evaluate performance.

Call Center Technology. Call Center technology includes call monitoring software to record, review, and evaluate service calls. This software records all audio calls handled by PSRs during normal business hours and all after hours (24/7) NAL calls. Every month, the Provider Services Quality lead audits calls for each PSR, to evaluate the accuracy of information provided. If we identify any opportunities for improvement, we provide training and coaching.

Measuring Caller Satisfaction. At the end of each call, our PSRs notify providers of the opportunity to participate in a post-call survey. We report internally on these results every month aggregated monthly to identify PSR training, education, improvement opportunities.

Our annual Provider Satisfaction Survey asks providers about their Call Center experience, and we include these results as part of our analysis. ***In our 2021 Provider Satisfaction Survey, 88% of respondents rated our Call Center service experience as well above average, somewhat above average, or average.***

Additional Pathways For Provider Services

We will add Amazon Connect technology to the Call Center for the new contract to improve the service experience. Providers will benefit from reduced wait times and an increased menu of self-service functions through the most comprehensive cloud telephony program available today. Advantages include the option to use a chat function with Provider Services Representatives (PSR), an option to have a PSR call back, automated entry of identifying information to help with skills-based routing to PSRs, real-time and historical analytics, and intuitive management tools. This enhancement is a response to Provider Satisfaction Survey feedback that identified a need to lessen providers' administrative burden. Benefits of Amazon Connect include:

- **Virtual Assistant Chat Bot.** We will meet providers where they are by implementing Virtual Assistant chatbot

technology that provides human-like and natural communication capabilities. Through the Virtual Assistant, we will offer real-time assistance for providers navigating our website.

- **Live Chat.** Web/Mobile Chat will allow providers to start a chat with an agent, step away from it, and resume the conversation when ready. Live Chat will be available for both English- and Spanish-speaking callers.
- **Speech Recognition.** Automated self-service capabilities for both voice and chat using natural language processing will capture provider input using speech recognition, making it possible for providers to quickly and efficiently complete simple transactions on their own.
- **Right Call / Right Agent.** Contact flows and skills-based routing will allow us to personalize the provider experience when contacting our Call Center agents. This advanced routing functionality will ensure that providers reach PSRs who are experienced and ready to resolve their particular issue or concern. This will minimize caller time spent on the phone, reduce transfers and wait times, and increase PSR capacity to support providers through any complex issues.
- **Sentiment Analysis.** We will use transcribed calls to analyze behavior and emotion based on caller interactions. This will help us understand how callers and PSRs feel in real-time and more easily identify situations where additional assistance is needed. We will more easily be able to identify expressions of dissatisfaction to initiate service recovery efforts. By using the important voice of the caller data, we will be able to better analyze PSR conversations using speech transcription, natural language processing, and intelligent search capabilities and ultimately identify emerging trends and opportunities for improvement earlier.
- **Post-Call Surveys.** Amazon Connect will also offer providers the ability to complete surveys at the end of their call to answer quick questions about their call experience with our representatives and what we can do better next time.

In addition to the phone line, providers can always reach our Provider Relations team through email. Our Provider Relations Representatives' email addresses are posted online. We have inboxes for network management and the Provider Relations team that are monitored daily and responded to within 24 hours.

43. Describe the Bidder's proposed provider education and training program, including:
• A description of the training program.
• A work plan that outlines education and training activities, including the frequency of office visits to conduct activities.
• A listing of the types of materials and content the Bidder will distribute (include three samples of materials).
• How the Bidder will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.
Page Limit: 5 Excluding sample materials

Nebraska Total Care's provider education and training program begins before providers join our network and continues through orientation and operations. Our ongoing efforts involve multiple in-person trainings with our Provider Relations Representatives and webinars that providers can attend virtually. We will continue to participate in forums with provider associations throughout the State and host quarterly Town Hall meetings open to all providers. We supplement these activities with a set of targeted communications, all of which we post on the provider website.

We train all provider types, including specialists in Behavioral Health (BH), Physical Health (PH), dental, pharmacy, non-emergency medical transportation, and vision. We share information about all components of our Medicaid managed care offering and MLTC requirements, including limitations on provider marketing, identification of special needs of members, including the LTSS population, and the appropriate utilization of ED services, including for BH emergencies.

Training Program

Our provider education and training program includes:

- Pre-enrollment education
- Initial provider orientation
- Provider Association meetings and quarterly provider forums
- Ongoing and targeted education
- Ongoing review of relevant materials and content distribution

Pre-Enrollment Education. During our first meetings with prospective network providers and provider associations, our Provider Relations Representatives and our executive leadership team educate them about Nebraska Total Care and how managed care works; our provider support services, including the Provider Services toll-free telephone line; and the benefits of being a Nebraska Total Care provider.

Provider Orientation. We deliver a comprehensive provider orientation based on MLTC standards within 30 days of a new provider joining our network. We can deliver orientations in any setting in person or through webinars. Provider orientation includes education about our provider services, prior authorization (PA) requirements and procedures, claims and payment procedures, accessibility standards, and training information. The following topics are covered during the orientation training.

- Nebraska Total Care and Managed Care Overview
- Contract requirements
- Limitations on provider marketing
- Identification of Members' Special Needs, Including LTSS
- Appropriate Utilization of ED Services, Including for BH Emergencies
- Claims Submission and Billing Tips
- Prior Authorization Guidelines and Submission Process
- Credentialing and Re-credentialing
- Public Website and Secure Provider Portal
- Care Management Services
- Medical Records Retention Review
- How to Submit a Provider Complaint
- Quality Improvement Program Overview
- Value-Added Services
- Clinical Practice Guidelines
- Support Services (Provider Services line, Provider Relations Representatives, and after-hours support)
- Covered Services (including BH, Dental, Vision, Pharmacy, and Transportation) and non-covered services
- Member Rights and Responsibilities
- Reporting Fraud, Waste, and Abuse

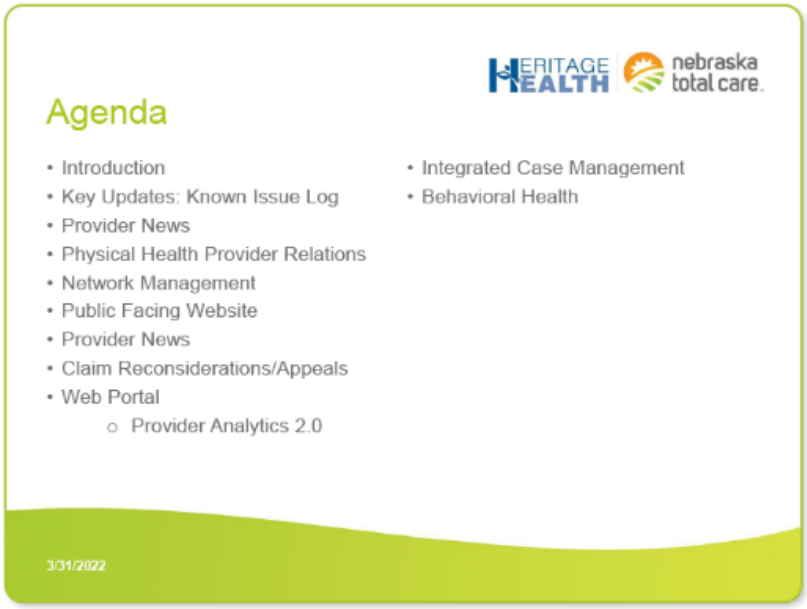
Provider Association Meetings. We will continue to participate in Provider Association meetings as requested and at regular intervals – monthly, quarterly, or semi-annually – that meet our stakeholders' needs. Our ongoing meetings with provider associations include but are not limited to the Health Center Association of Nebraska, Nebraska Association of Behavioral Health Organizations, PT/OT/ST associations, Nebraska Association for Home Healthcare and Hospice, Nebraska Hospital Association, Nebraska Health Care Association (representing nursing facilities and assisted living communities), Nebraska Chiropractic Physicians Association, Nebraska Medical Association, and local health departments. We consistently attend the State's quarterly Tribal consultations. To promote direct communication, we provide phone and email information for our senior leadership team and a key contact list for all our association partners.

Quarterly Provider Town Hall Meetings. We will continue to host our quarterly Town Hall meetings throughout the State.

We base the agenda for these meetings on provider news, critical updates related to doing business with Nebraska Total Care, and provider feedback and trends. Staff from our Clinical and Quality Improvement departments are regular presenters at these meetings. We ask for feedback at each event through evaluation forms, Q&A sessions, and informal discussions, and we implement process and program improvements based on what we learn. Our recent Town Hall meetings have been virtual due to the COVID-19 Public Health Emergency, and we have seen increased attendance with approximately 90 providers in a typical quarterly session. While we acknowledge the advantage of increased access through the online format, we value the in-person presence. Therefore, future meetings will be available both in-person and virtually.

Figure 43.A shows the agenda of our March 2022 meeting, which covered a variety of topics that we included based on provider questions expressed through our Provider Relations Representatives, Provider Services line, and Advisory Committees.

Figure 43.A Quarterly Town Hall Agenda



Ongoing Provider Training and Education. We offer training for providers to refresh their learning on a variety of topics, including claims submission, the Provider Portal, PAs, HEDIS measures, and evaluating their performance through the Consumer Assessment of Providers and Health System Survey. Trainings are a combination of face-to-face, teleconference or web conference, and pre-recorded sessions. We document training sessions and attendance and make this available to MLTC on request. We create ***provider tip sheets and quick reference guides*** for topics where we see a particular need or trend, so providers have a quick reference for important issues, such as transportation, HEDIS, and how to submit authorization requests through the Provider Portal. We add training sessions based on feedback from providers and MLTC. In 2021, our most popular training series was on Motivational Interviewing, with 140 attendees for the two-part course. To allow for provider scheduling flexibility and the proper ratio of instructors to providers, we offered five sessions each for Part 1 and Part 2.

LTSS training. We offer training and education for nursing facilities regarding billing procedures for when a member transitions from a skilled to a custodial level of care. Our Provider Relations team brings a level of expertise to LTSS service because all our representatives work with providers regarding our HIDE SNP products, and there is substantial overlap in providers between the two lines of business. Our representatives have training on Medicare and Medicaid policies. They led our Medicare provider Town Hall meetings before implementation and, with support from our team of national experts, regularly lead provider orientations. At a minimum, we update the provider billing guide annually, and we work directly with nursing facilities to educate providers and resolve billing and claims questions. We share updates with providers through the bi-weekly newsletter and the provider news page on our website.

Clinical Training. We offer training and education courses through our comprehensive clinical training program, which we can deliver in person or via webinar. Our provider training enhances the knowledge, skills, and performance of health care professionals who support members to make positive health behavior changes. We offer many courses to support continuing education, enhance integrated care, and expand the use of best practices. Participants receive CEUs for some

classes and certificates of attendance related to certain licensing requirements.

Multiple training topics explore ways for PH and BH providers to coordinate services, such as integrated care, cultural competency, common psychotropic medications, positive psychology, the strengths-based treatment model, and motivational interviewing. The Centene Advanced Behavioral Health series offers training for both BH and PH providers at no cost, through live instructor-led webinars. Training includes BH 101 (for PH providers), co-occurring disorders, cultural competence, de-escalation techniques, perinatal mood and anxiety disorders, recovery principles, and Trauma-Informed Care. Our trainers have extensive knowledge on a variety of health topics, including BH, speech, respiratory, occupational and physical therapy, nursing, exercise physiology, nutrition, diabetes, smoking cessation, Care Management, Care Coordination, UM and foster care.

Specialized Services for Dental Providers

Nebraska Total Care, through our wholly owned Subcontractor, Envolve Dental, Inc., will provide targeted education, issue resolution, and administrative support with two dedicated dental-only Provider Relations Representatives and a dental services Provider telephone line.

Care Management and Disease Management Program Training. Provider education and training on these programs are critical for facilitating coordinated care that complies with evidence-based guidelines and improves member health outcomes. This training occurs on an ongoing basis, but no less than semi-annually. Training topics include Nebraska Total Care programs that address the State's greatest needs; one current session is on delivering culturally and linguistically appropriate services in maternal care. We educate providers on how to refer members for enhanced services. The training addresses new requirements, processes or initiatives, program priorities such as coordination requirements, and program performance measures and results.

Education and Training Work Plan

Our Education and Training Work Plan is detailed in Table 43.A below.

Table 43.B Education and Training Work Plan

Activity	Frequency of Office Visits	Topics Covered
New Provider Orientation	Within 30 days of execution of Provider Contract	Provider Handbook; Covered Benefits; Outpatient Treatment Requests; Clinical Documentation; Integrated Health Care; Cultural Competency and Health Equity; Member Outreach; 24-hour NAL Services; Pharmacy Services Overview; (including formulary); Dental Services Overview; Case Management; PA Process Policies and Procedures; Preventive Services: Medicaid Policies (including updates); Person-Centered Planning Process, HCBS settings per CMS regulations; Information Technology, Provider Billing Guide, and Systems Operations; Provider Requirements and Responsibilities; Role of the Care Manager and the importance of notifying a member's Care Manager of any significant changes in the member's condition or care **Secure Provider Portal:** Referral and Screening; Billing and Claims Submission (including sample claims and review of remittance advice form); Claims Dispute Resolution Processes; Eligibility Verification Process; Provider Portal
Routine Office Visits	Monthly to Quarterly, depending on need	Provider Relations Representatives can complete 1:1 training with providers, particularly on billing or claims issues. They cover specific information about each provider's billing and claims payment performance, including using 90 Day Provider Claims Reports to share information, such as a claims payment summary; denial reports that include reasons for each denial; negative balance reports; and turnaround time reports so providers can see how quickly they bill and length of claims processing time from the original date of service. These reports are a valuable tool for Provider Relations Representatives to tailor billing and claims education to the specific needs of each provider. Office site visits provide an opportunity to review member materials with office staff, including the "Emergency Department: When to Use It, When Not to Use It" brochure, the "Are Your Children Being Poisoned by Lead?" brochure, and a dental check-up reminder card. We distribute a variety of provider education materials during office site visits, including the "How Nebraska Total Care Helps Your Patients" flyer, which highlights our various member benefit

Activity	Frequency of Office Visits	Topics Covered
		programs and how office staff can help spread the word.
Joint Operating Committee (JOC)	Quarterly or more frequently if needed	Our Provider Services team facilitates JOC meetings with hospital systems and other large provider groups to routinely discuss member quality initiatives, VBP reporting education and support, analyze network access and availability, share staffing and progress on collaborative partnership initiatives.
Specialized Training For PCP, PCMH, FQHC, RHC, BH Clinical trainers lead all sessions *Class is pre-approved for nursing CEU credits	Varies depending on training in person or virtual	**Monthly:** Documentation Guidelines; SMART Goals **Quarterly:** Cultural Competency: Moving from Cultural Competency to Humility*; Ethics (even years only for license renewal periods); Guidelines for Native Populations*; Motivational Interviewing Pt 1*; Motivational Interviewing Pt 2*; Providing Services for LGBTQ+ Population*; Psychotropic Medications; Social Determinants of Health*; Stages of Change*; Strengths-Based Treatment*; The Adverse Childhood Experiences (ACE) Study*; Trauma-Informed Care* **Twice per year:** BH 101*, six-class series for PCPs and other non-BH specialists (Anxiety, Bipolar, Depression, PTSD, Schizophrenia, Substance Use Disorder [SUD]); Co-Occurring Disorders; De-Escalation*; DSM Module 1; DSM Module 2; Eating Disorders; Positive Psychology; Poverty Competency*; Provider Screening Tools*; Recovery Principles*; SBIRT*; Suicide Risk Module 1*; Suicide Risk Module 2* **Annually:** ICD Module 1; ICD Module 2; Perinatal Mood & Anxiety Disorders*; Sex Offenders Overview; Stress Alleviation
Provider Association Forums and Town Hall Meetings	Quarterly in-person or virtual	We invite community stakeholders to Town Hall forums and frequently invite them to lead the discussion. We base the agenda for these meetings on provider news, critical updates related to doing business with Nebraska Total Care, and provider feedback and trends.
On-Demand Training	Available on Provider public website	Case Management Services; Follow-up Care for Children Prescribed ADHD Medication (ADD); Long-Acting Injectables Preventing Readmissions; Use of First Line Psychosocial Treatment for Children and Adolescents on Antipsychotics (APP). These trainings are available in the "Provider Training" section of the website.

Types of Materials and Content Distribution

We supplement our formal education and training with regular communication with clinical and non-clinical provider office staff.

Provider Website. Our provider website offers a comprehensive Provider Resource Center which includes a Practice Improvement Resource Center, Provider Newsletters, Provider Training, and Clinical and Payment Policies. All information on the website is publicly available, while the Provider Portal is where providers (sign-in required) submit claims and any information that involves patient identifiers, confidential data, or sensitive information. We determine jointly with MLTC what approved content to include on the website. Information on the website is searchable and includes, at a minimum:

- Provider Handbook and related policies and procedures
- Provider Billing Guide, including EPSDT Billing Guide
- MLTC bulletins that apply to Nebraska Total Care and providers
- Telehealth Resource Guide
- Cultural Competency Resources
- Clinical Practice Guidelines
- Information on upcoming provider training
- Provider training manuals
- Information about the provider and member grievance system
- Information about obtaining PAs and referrals, including whether PA is required
- Nebraska Total Care formulary and Nebraska's Preferred Drug List
- Nebraska Total Care's pharmacy PA requirements
- Updated MAC pricing
- Instructions on how and whom to contact for questions about filling prescriptions
- Information about contacting Nebraska Total Care's Provider Services staff

- Information on Care Management, including links to submit a referral request, and disease management referral forms
- Pregnancy Support including Notification of Pregnancy Forms
- Link to MLTC website and other related sites
- Link to Nebraska Total Care's corporate website
- MLTC-approved formulary changes and PA requirements, clinical criteria, and revisions, at least 30 days before the effective date of the change

We will review the website as part of the implementation of the next contract and submit updates at least 120 days before the start of the contract. Throughout the contract, we will submit changes and receive MLTC approval 60 days before implementation, following recent legislative action regarding material changes.

Additional Provider Materials:

- **Bi-Weekly Newsletter Via Email:** We keep providers updated on policy and procedural changes, scheduling of our Town Hall meetings and other community events, and similar everyday matters.
- **Quarterly Provider Newsletter:** These newsletters offer in-depth information about Nebraska Total Care programs. For example, in 2022, our first two newsletters covered topics such as the Start Smart program and provider incentives for submitting a Notification of Pregnancy form; best practices and screening tools for diabetes, bipolar and schizophrenia, women's health, and EPSDT; and an overview of our Quality Assessment and Performance Improvement program. This newsletter educates office managers, administrative, and billing staff on topics such as billing and PA changes, coding tips, Quality and Care Management updates, and notice of new or changes to existing policies.
- **Explanation of Payment (EOP) Inserts:** We use EOP envelope inserts to circulate information to providers. For example, we have included an insert on Electronic Data Interchange information with paper checks to educate providers about the benefits of submitting claims electronically.
- **Quick Reference Guide:** This guide, available on our provider website, includes key contact information, authorization and referral information, and other essential information for providers.
- **Ad Hoc Email Communications:** We find email blasts to be especially efficient and effective in reaching providers with urgent information about the regulatory, contract, or other changes on an as-needed basis. Our emails include a return phone and fax number and other contact information so providers can easily connect with us.

Sample materials. We have provided the following samples of provider materials as attachments: ***Attachment B.43.A 2022 Q1 Provider Newsletter***, ***Attachment B.43.B 2022 Provider Billing Guide***, ***Attachment B.43.C Town Hall Presentation***, and ***Attachment B.43.D HEDIS Quick Reference Guide***.

Evaluating Usefulness of Educational Sessions and Using Feedback to Influence Training

At the end of every provider training session, we distribute an evaluation to measure the effectiveness of training and obtain provider feedback and suggestions for improvement. We track provider participation and use that information as a resource if we identify a performance issue with a provider who did not participate in training. Our Provider Relations Representative tracks attendance, saves sign-in sheets and evaluation forms, and submits a field visit entry. We store this information on our internal SharePoint site and review it to assess representatives' job performance and to identify opportunities to enhance our communication with providers.

Our annual Provider Satisfaction Surveys also include questions about our training programs. Based on provider feedback from orientations and the annual Provider Satisfaction Survey, we now follow an enhanced process for new provider orientations due to the increased importance of educating providers about Nebraska Total Care and MLTC policies.

Lastly, we seek and record feedback through our Provider Advisory Committee, Clinical Advisory Committee, Behavioral Health Advisory Committee, and Tribal Health Advisory Committee. For example, recommendations made by the Clinical Advisory Committee led to adoption of the Behavioral Health Practice Guidelines for Gender Reassignment and Transgender issues as well as offering provider training on providing services for LGBTQIA+ patients in 2021. We have updated this training for 2022, now titled Cultural Competent Care and the LGBTQIA+ Community. ***To date, we have trained 18 provider groups over four training sessions in 2021 and 11 providers over two training sessions in 2022.***

44. Describe the Bidder's proposed approach to promoting communication between providers and the Bidder. Include a discussion of how the Bidder will work with providers to improve administrative efficiencies and engage providers in developing and monitoring clinical policies and operational issues. Discuss how the provider network liaison will work with the Provider Advisory Committee to respond to provider concerns, develop provider training, and enhance MCO-provider communication strategies. Provide examples of how the Bidder has successfully collaborated with providers to identify necessary changes and how these changes have been implemented.

Page Limit: 2

Our Provider Relations team is at the heart of our communications with providers. As soon as a provider joins our network, we schedule a new provider orientation with a Provider Relations Representative. We assign each provider an individual representative based on geography and the representative's knowledge of a particular specialty. Providers can contact their representative via work phone or email with any service-related questions, including assistance with claims payment. We post frequent news bulletins and policy updates on our website to promote ongoing and seamless communication.

Working with Providers on Administrative Efficiencies, Clinical Policies, and Operational Issues

We participate in regular communications with providers through our Provider Relations team, UM and other clinical functions, and our Provider Advisory Committee and subcommittees. A provider's suggestion for improvement can come from a regularly scheduled meeting with the Provider Relations Representative, a public forum or committee meeting, an email in advance of or in response to a meeting, or a direct request to an executive on our senior leadership team. We respond quickly to acknowledge receiving the provider's feedback, evaluate the suggestion, and determine how we can help to address their concerns.

"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."

- Dr. S. Pirzada Sattar, Medical Director, Inroads to Recovery

Liaising with the Provider Advisory Committee

The Quality Assurance and Performance Improvement Committee (QAPIC) oversees all Nebraska Total Care committees. The QAPIC integrates into all areas of operations–such as clinical, claims payment and accuracy, and member and provider satisfaction. This group closely monitors program enhancements through development and implementation. Within this committee structure, we involve providers in several specific committees, all of which meet quarterly:

- **Provider Advisory Committee (PAC).** This group includes 10 providers representing a broad range of disciplines and settings. Our COO, Chief Medical Officer, and Pharmacy Director are part of the committee, as well as representatives from the QI, Provider Relations, and Network Development departments. Providers on the PAC, as listed in our response to Question V.J. 41, represent associations for BH, therapy, Critical Access Hospitals, and independent pharmacies. We include multiple rural representatives. We will recruit a PAC member representing Tribal health, supplementing the existing Tribal Health Advisory Committee, and a dental provider.
- Nebraska Total Care distributes an agenda that focuses on standard items such as quality improvement, data sharing, and operational process improvement opportunity discussion. We dedicate a substantial amount of time for an open forum where providers can provide feedback and engage in dialogue. Our Provider Network Liaison is Mariana Johnson, our Senior Manager of Provider Relations/Claims Educator. She attends PAC meetings and is responsible for seeing all action items through to completion. She responds to individual provider concerns, develops provider training opportunities, and enhances MCO-provider communication strategies. We report back to the providers and the PAC as a whole on the progress of each task before the next meeting.
- **Clinical Advisory Committee (CAC).** The CAC focuses on clinical policy review and discussion of Clinical Practice Guidelines. For a full description of the CAC, see our response to Question V.M.72.
- **PAC Subcommittees.** Our subcommittees focus on serving members and providers with unique needs.
  - **Behavioral Health Advisory Committee.** The Behavioral Health Advisory Committee involves six providers and Nebraska Total Care leadership, including Networking and Provider Relations departments, and our Clinical Provider Trainer. We regularly coordinate meetings with other MCOs, delivering training and presentations on topics related to BH and therapy.
  - **Tribal Health Advisory Committee.** This group includes six providers, our Tribal Liaison, and representatives from Quality Assessment and Performance Improvement (QAPI) and Community Health Services departments. They meet quarterly in person or by phone to discuss quality trends, billing updates, new or enhanced programs, and future provider training. Through this Committee, we wrote guidelines for working with the Native American

population, receiving support and final approval from all four tribes.

Examples of Identifying and Implementing Necessary Changes

We make program or process improvements based on provider feedback, whether from direct outreach or the committee structure. The following examples show a broad mix of the two:

Authorization Process Work with PT/OT/ST Associations. We have been engaged with trade and provider associations since we began operations. When we chose a vendor to administer the Therapy Utilization program through post-pay review processes, associations expressed concerns through the Provider Advisory Committee. Discussions led to several administrative changes over the years that improved member access and provider satisfaction. Specifically, Nebraska Total Care:

- 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 of therapy.
- Increased the length of time authorizations are valid, thereby decreasing concurrent reviews for continued care requests.
- Enacted a policy of administrative authorization for 12 sessions of therapy, annually per discipline, for post-op patients.
- Extended administrative authorization for 12 sessions to all members needing this service, as of April 2022.
- Implemented a system configuration to automate this authorization, eliminating the need for requests and approval processing, on July 1, 2022.

Our data-driven approach allowed us to analyze the PAC's suggestions and implement changes that reduced administrative burden and improved our relationship with providers. As part of this improvement process, the PAC continues to monitor therapy authorizations.

"Nebraska Total Care's pre-authorization system is user-friendly and they are more than willing complete education and put the patient first at all times. They have recently accepted that 12 physical therapy visits are allowed without authorization. This is a very patient-first mentality and is very much appreciated. It is also very much respected that their pre-authorization system exists in-house. In other words, they do not use a 3rd-party company. When there is an issue with an authorization, Nebraska Total Care's staff is extremely helpful, readily available, and consistently willing to do what is best for the patient."

-Brian Brunken, Board-Certified Clinical Specialist in Orthopedic PT, Practice Management Committee Chairperson

Children's Hospital Administrative Relief. Our community partner, Children's Hospital, explained their nursing staff shortages and asked if we could provide administrative relief. After a comprehensive review of Children's Health and Children's Home Health authorization data, we identified outpatient services accounting for 33% of their authorization requests where we could remove the authorization requirement based on the facility's history of performance

Home Health PAs. During a UM meeting with a home health provider, issues arose regarding staffing for members with complex conditions, especially in rural areas. The provider expressed concerns about timely authorizations and member access to care. Our UM team changed policy to allow services to begin as soon as staffing was available, even when clinical documentation was still ongoing. We coordinated care with other agencies and the home health provider to meet members' needs, involving our Care Management team and DHHS when necessary. Our new approach has led to a 50-75% reduction in wait time to access medically necessary services.

Member self-referral for Care Management. In April 2020, a committee member who is an urgent care provider asked if members can initiate the Care Management process because there are often challenges finding providers who accept Medicaid. We reiterated that members can begin this process, and we made information about this option available through the Member Services line, our member website, and the mobile application. Providers agreed that this is a valuable resource to allow members to receive services outside of urgent care and that it was especially timely given the surge in vulnerable patients due to isolation as a result of the Public Health Emergency.

Anti-Gag Clause

As part of orientation, we confirm our adherence to the anti-gag clause, according to 42 CFR 438.102(a)(2) and as required by RFP Section V.J.7, Provider-Patient Communication/Anti-Gag Clause. We do not prohibit or otherwise restrict a health care provider, acting within the lawful scope of their practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. We support providers delivering any information the member needs to decide among treatment options, including the risks, benefits, and consequences of treatment or non-treatment.

45. Provide a description of the Bidder's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the Bidder will acknowledge and resolve inquiries and grievances. Explain how the Bidder will track provider complaints and how the Bidder will use this type of information to improve provider services. Include a description of any type of internal reporting the Bidder will perform, and how the Bidder will use reporting information to influence the activities of the Bidder's provider services representatives.
Page Limit: 3

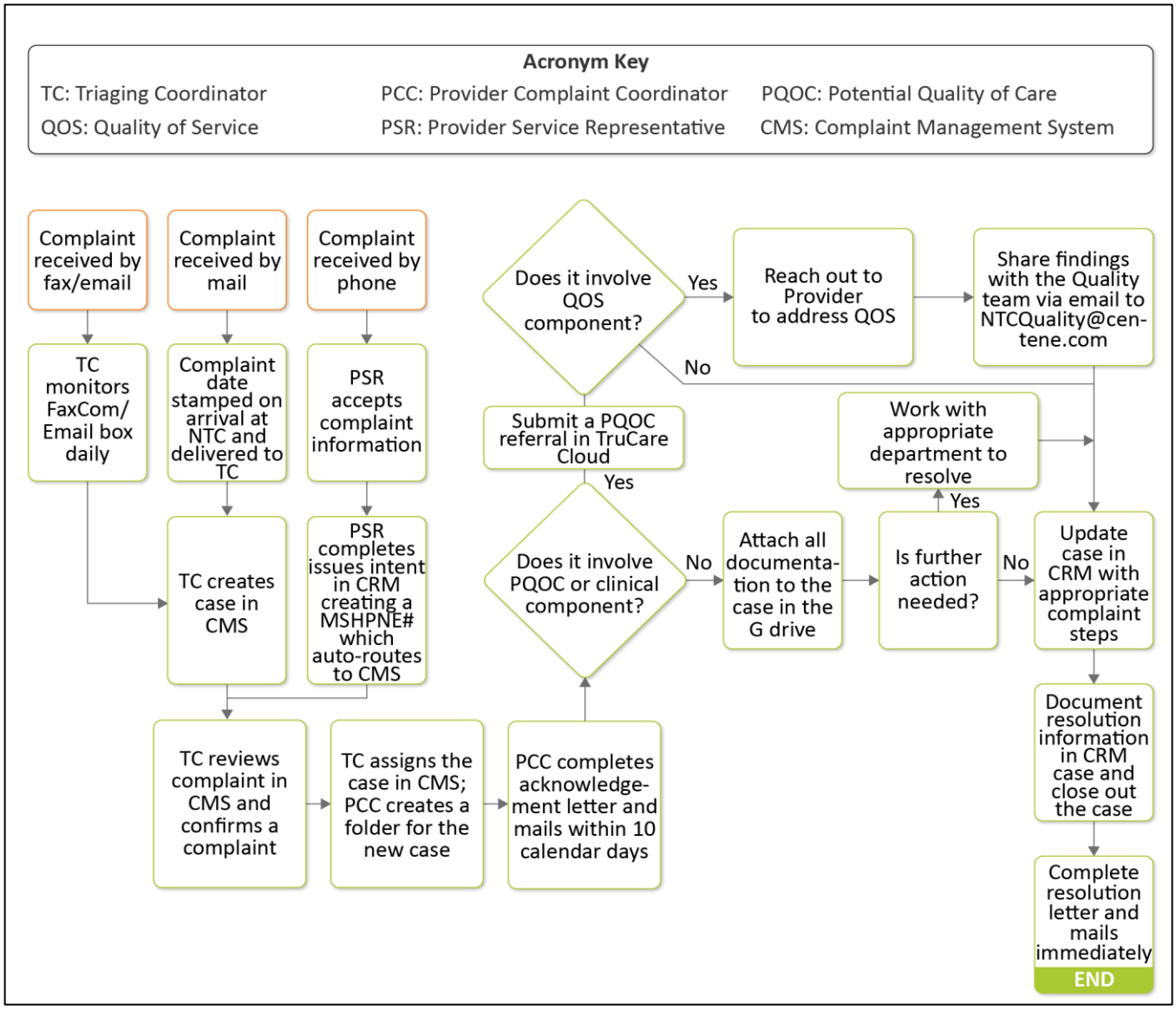
The responsiveness of our field-based Provider Relations Representatives and Call Center PSRs results in quick resolution. In our 2021 Provider Satisfaction Survey, 84% of respondents said we respond timely to outreach, the highest positive response of any question in the survey. Because of the immediate attention we give to providers' concerns, ***we have reduced provider complaints by more than 50% each year since 2019.***

We recently updated our policies and procedures to incorporate the State's broadened definition that a complaint is "any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO."

Approach to Handling Provider Complaints

Our process for handling complaints complies with all MLTC regulations. **Figure 45** details our process for acknowledging and resolving provider complaints. Our provider complaints are managed through the Grievance and Appeal system allowing for electronic tracking, workflow, and data management, and provides capabilities to attach documentation pertinent to the complaint.

Figure 45 Provider Complaint Process



We will update our policies and procedures as needed and submit them for State review and approval at least 60 days prior to the new contract start date. Within 15 days of contract execution, we will submit the names, phone numbers, and email addresses of Nebraska Total Care executives with the authority to require corrective action. If there are any changes in these positions during the life of the contract, we will provide updated information within two business days.

We educate providers on how to contact us to file a complaint during orientation and through our website and Provider Handbook. We describe the methods and staff responsible for the receipt, acknowledgment, investigation, and timely resolution of provider complaints. Our Provider Relations and Provider Services staff are available to answer questions about the provider complaint process and ensure members can effectively navigate the process and access provider complaint staff.

Intended Interaction and Correspondence

If a provider files a complaint–either written, by phone, or in person–our Provider Complaint Coordinator (PCC) logs the complaint into our complaint management system. The PCC addresses, processes, and resolves complaints. The PCC investigates each case, reviewing pertinent facts from all involved parties and any documentation submitted by the requesting provider.

In the complaint record, we log the date we receive the complaint; provider or group filing the complaint; nature of the complaint; associated provider number; whether the provider is in-network; date of service or incident; whether an extension was requested or agreed upon; complaint due date; and the final decision date. The PCC works with appropriate internal staff (for example, Claims Liaisons for complaints related to a claim) to thoroughly investigate each complaint using applicable statutory, regulatory, and State contractual provisions and escalate the complaint to leadership as warranted.

Upon completion of the complaint investigation, we issue a timely written notification of resolution or results to the provider, including the legal and factual basis for the decision. Each resolution letter includes the nature of the complaint, discussion of the issues involved, the decision and reason(s) for the decision, applicable legal citations, contractual provisions, policy reference(s), and the provider's right to appeal by filing a written request to us, no later than 30 days after receipt of our resolution letter.

Timeframes to Acknowledge and Resolve Inquiries and Grievances

Providers may file a complaint orally, in person, or in writing, up to 30 days from an incident of concern or Notice of Action. The PCC will review the complaint and provide an acknowledgment within 10 business days and a written resolution notice within 30 days of receipt. If the complaint is not resolved in 30 days, the PCC or a supervisor will document the incident and notify the provider and MLTC of outstanding issues, including a timeline for resolution and reason for an extension.

Tracking Provider Complaints to Improve Services

By monitoring the inquiry age, our PCC can easily verify adherence to resolution timeliness. The PCC reports to the Chief Operating Officer, who oversees both member and provider grievances and appeals. Integrating these functions allows us to identify, track, and address provider and member concerns – which are often related -- across the enterprise and continuously achieve plan-wide service improvements. We conduct a monthly review of issues and the most frequent reasons for calls to our Provider Services line. We assign each item to an issues log and track to resolution.

Nebraska Total Care reports monthly on all provider complaints and complaint drivers for both Medicaid and Medicare, including our HIDE-SNP program. We incorporate this data into our market-level executive review of performance measures. Our Provider Services Manager and our Provider Relations team identify opportunities to educate providers on key complaint drivers. Examples of service improvements include member billing education. In response to complaints and inquiries, we shared information on the provider newsroom site and in the bi-weekly newsletter about prohibitions on balance billing and billing for missed appointments.

If complaints related to reimbursement require rate discussion, our Contracting team leads follow-up discussions. Our Provider Relations team handles claims and billing complaints, often establishing standing meetings with providers as needed. They develop a comprehensive work plan and track progress to resolution.

46. Describe the Bidder's plans and ability to support network providers' use of electronic health records and current/future federal IT requirements. ***Page Limit: 1***

Ability to Support Provider Use of Electronic Health Records (EHRs)

Through efforts such as the recently completed Nebraska Electronic Health Record (EHR) Incentive Program, all of Nebraska Total Care's network acute care hospitals, and the majority of our other providers, including PCPs, Critical Access Hospitals, and Rural Health Centers are now using EHRs. Thus, our focus now is supporting processes that leverage our providers' EHR investments to improve care and minimize provider administrative burden. For Nebraska Total Care Network Providers who need assistance in implementing EHRs, we will offer support from our Technology Enablement Fund. This Fund assists providers with costs associated with EHR adoption, including hardware and software that may be needed to operate an EHR as well as for data connectivity to Nebraska's Health Information Exchange (HIE), CyncHealth. For our providers with no EHR, we offer our secure Provider Portal, with access to member clinical, administrative, and demographic information and secure communications with Nebraska Total Care.

Interoperable Management Information System (MIS). 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. We use interoperability capabilities such as Fast Healthcare Interoperability Resources (FHIR) and Health Level Seven International® (HL7®) standards for exchanging health care information electronically. This standardization allows us to automate the extraction of EHR data and deliver insights back into EHRs such as EPIC 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.

Easing Provider Burden through EHR Use. Today, our clinical staff securely access EHR systems at several network provider organizations including Bryan Health, Children's Hospital, and Methodist, to perform concurrent reviews for members in inpatient (IP) care. Our use of provider EHRs not only improves timely access to the most current clinical information for our staff ensuring timely reviews, it also streamlines the concurrent authorization review process and determination timeline and alleviates the burden on our hospitals to produce clinical documentation needed for review.

Leveraging Provider EHRs to Streamline Care Coordination. Through our participation with CyncHealth, we electronically receive ADT notifications from hospital EHRs, and we use this data to enhance care coordination with our providers. When we receive IP admission as well as discharge IP ADTs, these efficiently trigger care planning and care coordination activities of our Care Managers with the hospital and outpatient providers caring for our member. In addition, when we receive IP discharge ADTs from EHRs, we automatically update the corresponding IP authorization request, saving the hospital the time to notify us. When we receive Emergency Department (ED) ADTs from the provider EHRs via CyncHealth, our Care Managers will outreach as needed to the appropriate PCP for follow-up care to prevent unnecessary readmissions. We also make all ADT information we receive securely available to all our providers via our HIPAA compliant Provider Portal, assisting our hospitals with an additional, complementary method of notifying all affected providers of hospital events.

Automating IP Authorization Requests from EHRs. We are piloting the automated creation of IP Prior Authorization requests (PA) with our network provider Great Plains Health in North Platte, based on ADT data from their EHR, sent to us via CyncHealth. In this pilot, when we receive an IP admission ADT in real time from Great Plains, our TruCare Cloud care and utilization management platform automatically builds an IP Authorization Request, eliminating the need for Great Plains to make a PA request. We plan to communicate to our providers the benefits of this automated IP PA capability and make it available to interested providers over the course of the contract.

Supporting Efficient Care Quality Processes through Provider EHR Use. We securely receive monthly and quarterly HEDIS Supplemental Data Set (SDS) information from the EHRs of 14 of our largest providers, including CHI, Bryan, NHN, SERPA, and five FQHCs. SDS contains clinical data not otherwise available from claims, and we process this information to identify closures in care gaps and to use for clinical quality monitoring and reporting. 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.

Supporting Dental Providers. Through our participation in CyncHealth, Envolve Dental, Inc. will have secure, efficient access to dental records on our members from our dental providers using EHRs. Through our access to dental EHR records, we will further enhance care coordination and our ability to monitor closures in dental care gaps with a minimum amount of administrative burden on our dental providers.

Collaborating to Drive New EHR Applications. We partner wherever possible to promote the use of EHRs. Our Quality Management Coordinator is a member of Nebraska's Health Information Technology Board, and our Medical Management Coordinator sits on CyncHealth's Data Quality Committee.

47. Discuss how the Bidder will engage and educate PCPs about their role in the provision of behavioral health services and the coordination of co-existing conditions.

Page Limit: 2

By engaging and educating PCPs about their role in providing BH services and coordination of care for co-existing Physical Health (PH) and BH conditions, we expand access to services for some of our most vulnerable members.

PCPs are responding to our efforts and becoming more comfortable with providing BH services, which is reducing crisis events. In 2021, our payments to providers showed a 36% increase in BH-related PCP spending, while BH-related inpatient stays and ED visits decreased by 26% and 2%, respectively. PCP spending for those involved in the Foster Care System increased by 37%, with larger declines in inpatient (42%) and ED (48%) spending.

Engaging PCPs in BH Services Provision

We assist PCPs in connecting members to BH services by providing financial incentives and coordinating referrals and care jointly. We hold monthly meetings with our high-volume participants in the Value-Based Purchasing (VBP) program. During these meetings, we encourage PCPs to identify members who might need help with one or more BH conditions, as part of our No Wrong Door Care Management referral practices. Our clinical and Quality Improvement staff also identify members who may be at risk based on recent utilization patterns and predictive modeling. Our collaborations include assigning either a provider or a Care Manager from Nebraska Total Care to reach out by phone to these members to make them aware of Care Management services. As needed, this includes completing an updated Health Risk Assessment and scheduling appointments with specialists.

Where appropriate, we hold bi-weekly care conferences that involve the member, Care Manager, a Nebraska Total Care Medical Director, and all relevant providers. To help us in these efforts, we have begun an incentive program pilot in Lincoln and Omaha, using Quartet, a platform to help members access BH services. Providers receive incentives for outreach, engaging, assessing members, and promoting their community tenure. Incentives are based on reductions in admissions/re-admissions to EDs, inpatient, and residential services. In more complex situations, such as those involving a member with repeated ED visits for PH and BH issues, care conferences will repeat until the member has stabilized.

We are partnering with the Health Center Association of Nebraska on Project Access, a new initiative to address workplace shortages at FQHCs. Nebraska Total Care will provide funding to increase compensation and improve work conditions at facilities throughout the State. PCPs at FQHCs are frequently the first line of service for patients with BH needs, and increased staffing will lead to better access for the more than 100,000 State residents who seek care annually at these community health centers.

Educating PCPs

BH Services Provision

Our provider education and training teach PCPs how they can provide BH services and how they can help patients access a specialist. Many of these trainings satisfy CEU credit requirements, as detailed in our response to Question V.J.43. Trainings include:

- BH 101, six-class series for PCPs and other non-BH specialists (Anxiety, Bipolar, Depression, PTSD, Schizophrenia, Substance Use Disorder [SUD]); Co-Occurring Disorders; De-Escalation; DSM Module 1; DSM Module 2; Eating Disorders; Positive Psychology; Poverty Competency; Provider Screening Tools; Recovery Principles; SBIRT; Suicide Risk Module 1; Suicide Risk Module 2
- Screening tools and best practices, including SBIRT as a Value Added Service
- Our No Wrong Door policy for referring members for Care Management, including an explanation of how to use the referral form stored on the Provider Portal, how to determine when crisis services are appropriate, and when to connect patients with BH providers, in person or via telehealth

Our BH Clinical Director, Dr. Wendy Welch, has been involved with MLTC as an advisor in the development of SUD services, Medication-Assisted Treatment (MAT), and medically managed inpatient withdrawal treatments. We have shared information with providers and MLTC, and provided training related to appropriate services to treat members with SUD.

We expect PCPs to share medical records and communicate with BH providers. Through orientation and regular communications, we educate PCPs about the availability of telehealth as a support service to them as well as a solution to members' access challenges. We tell PCPs how they can access these service options at any time:

- **Babylon Health.** Babylon utilizes leading-edge digital technology and artificial intelligence symptom checking tools to triage members 24/7 and determine the correct point of care. Members can initiate two-way video and/or audio consultation for pediatric and adult urgent care needs, and BH services including talk therapy, psychiatric care, prescription management, and preventive care, while maintaining accessibility for members with disabilities or limited English proficiency. For care coordination, Babylon shares virtual visit and follow-up care information with the member's PCP.

- **Babylon 360 Virtual PCP Platform.** As a new service under the next contract, Nebraska Total Care and Babylon use this data-based innovation to identify members who do not seek or receive primary care services and support them through telehealth. 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.
- **Brave Health.** This new service will offer a virtual Community Mental Health Center platform and model providing child, adolescent, and adult psychiatry; therapy; SUD care; hospital transition support; medication adherence intervention; and health navigation engagement telehealth services. Brave Health's Psychiatric Navigation Program (PNP) links members to a Navigator who conducts 1:1 check-ins and solution-focused brief therapy to ensure successful linkage for psychiatric evaluation. ***Preliminary outcomes include a 90% reduction in BH admissions and a 66% reduction in costs for individuals with a Brave Health encounter.*** The PNP has an 82% completion rate for child psychiatry evaluations, compared with 65% for children without PNP. Brave Health provides a value-based care resource model that will focus on 7- and 30-day follow-up visits after an inpatient admission, to support HEDIS measures improvement and reduction in inpatient readmissions.
- **ConferMED Specialty eConsults.** Nebraska Total Care supports the delivery of asynchronous, store-and-forward consults between PCPs, BH providers, and high-volume specialty providers to expand access, decrease specialty wait times, and reduce avoidable specialist visits, tests, and procedures. We leverage ConferMED to connect rural PCPs with specialty providers, supporting member consults, and coordination of care.

Coordination of Co-Existing Conditions

With 22% of our membership having co-morbid PH and BH conditions, we ensure Nebraska Total Care providers are well equipped to support members with co-existing conditions. We offer materials and training on clinical best practices for managing co-morbid BH conditions via our Provider Portal. Using our Patient Analytics solution, providers have an integrated view of their patient's physical and behavioral health diagnoses; and medication, lab, and care team data, driving clinical decision-making. As an additional support, providers can participate in case conferences to address the whole health needs of members with complex needs.

Nebraska Total Care Participates in DHHS' Integrated Care Task Force

Nebraska Total Care is proud to be represented by Adam Proctor, COO, on the 17-person board of the Integrated Health Care Task Force that is creating a new model for the integration of PH and BH care. The Task Force is the result of a five-year, $10 million grant from the Federal SAMHSA for the Community Alliance Integrated Health Clinic in Omaha, a partnership between DHHS and Community Alliance. The clinic began serving patients in July 2020, with a concentration on adults with Serious Mental Illness and was ahead of its target with 397 adults enrolled by the end of 2022. Staff includes a PCP, therapists, psychiatric medication management providers (via telehealth), Care Managers, Care Coordinators, and office administrators.

By offering services at the same location to patients who can be difficult to engage in care, and by addressing SDOH and medical concerns, the clinic has seen significant improvements in patients' health. In one 30-day period, 16 patients experienced a total of 291 "troubled nights" (unhoused, hospitalized, or in jail or detox). Six months later, 10 people experienced a total of 161 troubled nights. Similarly, patients self-reported positive responses to all seven questions about changes in their ability to manage daily life, including a drop (22% to 4%) in disagreement rate over six months to the question, "I generally accomplish what I set out to do". Mr. Proctor participates in quarterly board meetings and offers perspectives on strategies to shape the program. The Task Force goal for 2023 is to make suggestions to expand integrated care throughout telehealth, and the goal for 2024 is to determine how financing—including Collaborative Care Codes and other mechanisms that already exist in Medicaid—can align with integrated care. Mr. Proctor has held discussions with project leaders about ways to build primary care membership at the clinic, including PCP reassignment. Nebraska Total Care embraces our role in helping to create this system of the future and spreading it beyond the pilot to clinics throughout the State.

> "Nebraska Total Care staff have taken 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."
>
> *- Aileen Brady, COO, Community Alliance*

48. Describe the approach the Bidder will take to assess provider satisfaction, including tools the Bidder plans to use, frequency of assessment, and responsible parties. 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: 5

Nebraska Total Care's Quality Improvement department oversees a comprehensive approach to assessing provider satisfaction through which we offer providers the chance to evaluate our services on a daily, weekly, monthly, quarterly, and annual basis. Table 48.A describes the methods we employ to assess provider satisfaction. These methods include the annual Provider Satisfaction Survey and formal and informal feedback from providers through our committee structure, Provider Relations Representatives, Provider Services line, and Provider Portal.

Table 48.A Methods of Assessing Provider Satisfaction

Tool of Assessment	Frequency of Assessment	Responsible Party
Provider Satisfaction Survey	Annual	Provider Services Manager
Provider Complaints	Monthly	Chief Operating Officer (COO)
Provider Services Line Post-Call Survey	Monthly	Provider Services Supervisor
Board of Directors' Feedback	Quarterly	COO
Advisory Committee Feedback	Quarterly	COO
Community Outreach Events	As received	Marketing Manager

Tools to Assess Provider Satisfaction

Provider Satisfaction Survey. The most important and comprehensive method of assessment is the annual Provider Satisfaction Survey. Through this survey, providers have consistently identified Nebraska Total Care as their preferred health plan. Feedback from providers shows that we are especially strong in reducing administrative burden.

We use a random sample of 2,500 (1,200 PCPs, 800 specialists, 500 BH) from urban, rural, and frontier settings. Postcards are sent to all in-network providers selected for the survey followed by the first questionnaire one week later. Non-respondents are sent a second questionnaire the following month. Then we also conduct follow-up calls to non-respondents and offer them another chance to participate. Providers can answer questions by mail, phone, or Internet. In 2021, our responses had a 95% confidence level using the t-test.

The survey asks more than 50 questions about Finance, Utilization, Quality Management, Network/Coordination of Care, Pharmacy, Call Center, and Provider Relations. Based on these results, we create an action plan for the following year to target key areas where we can improve the provider experience.

This action plan identifies a staff person responsible for implementing each change, specific initiatives and deliverables, any barriers that we must address, and target completion dates. We share this action plan with the State and the Provider Advisory and QAPI Committees, and we review the plan quarterly. If the following year's Provider Satisfaction Survey shows sufficient improvement, we close out the item; otherwise, it remains on our action plan for the next year.

Strong Results in 2021 Provider Satisfaction Survey

- ***84% report*** that staff respond timely to outreach.
- ***83% are satisfied*** with the end-to-end payment process.
- ***82% are satisfied*** with the authorization and determination process.
- ***80% state*** that education regarding changes to prior authorization is clear and timely.

Provider Complaints. The COO oversees member and provider complaints, grievances, and appeals, which allows for integrated reporting and earlier identification of issues. We conduct a monthly review of issues and the most frequent reasons for calls to our Provider Services line. We assign each item to an issues log and track to resolution.

Provider Services Line Post-Call Survey. Our efforts to gauge and increase provider satisfaction are ongoing throughout the year. The Provider Services Line includes an option for providers to respond to a survey after all calls using touch-tone responses or leaving a recorded message. The Provider Services line supervisor reviews audible responses daily, transcribes the recordings, and categorizes them as compliments or complaints. We follow up immediately with the provider on all complaints. We review overall survey results monthly to identify trends and training opportunities.

Board of Directors Feedback. Our Board of Directors and committee structure are crucial to keeping us informed of our performance and any developing issues that we can address early. We recently refreshed the Nebraska Total Care Board of Directors with the deliberate intent to reflect the State's diverse provider and member population, in terms of both discipline and geography. For example, in response to the State's goal for maternal and infant health, we recently added a Neonatologist. To ensure representation to reflect the diversity of our State we have added a PCP from rural Nebraska. Our external Board membership now includes representatives from five hospitals/health systems, an FQHC, a County Health department, CyncHealth, and a health care leadership firm. We are actively recruiting to add a Medicaid Dental Provider to our Board. Our Board meets quarterly, chaired by Nebraska Total Care CEO Heath Phillips. Our COO and our vice president of network contracting are responsible for implementing any agreed-upon changes.

Advisory Committee Feedback. Our Provider Advisory Committee, Behavioral Health Advisory Committee, Tribal Health Advisory Committee, and Clinical Advisory Committee offer guidance during quarterly meetings, and through email and phone conversations. Our Provider Services Manager and Claims Educator review this information and enact changes as necessary. We will add representation from dental providers to this committee structure in recognition of the addition of dental services to managed care.

As noted in response to Question V.J. 44, the Provider Advisory Committee has been instrumental in creating procedures for therapy authorization that improve member access and reduce providers' administrative burden. Our Behavioral Health and Tribal Health committees have worked to develop training and documentation. Our Clinical Advisory Committee implemented a provider's suggestion to increase member awareness about the availability of Care Management services and members' right to self-refer.

In addition to those examples, the Clinical Advisory Committee has made the following improvements:

- CAC members continually consider gaps in access to treatment, provider education, and Clinical Practice Guidelines (CPG). A provider identified the underrepresentation of the LGBTQIA+ population in these clinical resources, despite the substantial health inequities this group encounters. The committee's discussion and recommendations led to the national adoption of Behavioral Health CPG for Gender Reassignment and Transgender Issues, and provider training titled Providing Services to LGBTQIA+ Population.
- The CAC discussed the high rate of BH hospitalizations for children in foster care, with insufficient aftercare. The Committee decided additional location data would help in making recommendations. We are finalizing a health equity dashboard for Foster Care that will allow users to drill down on this data. At the committee's suggestion, we reached out to hospitals, foster parents, and Child Protective Services caseworkers and learned that initial contact with the hospital supported Care Coordination and increased discharge planning with outpatient providers. In response, we are developing a Community Partner Portal, similar to our Member and Provider portals, that gives Case Managers direct access to member information for coordination of care.

Community Outreach. We distribute evaluation forms after all new provider orientation sessions and at provider association forums or Town Hall meetings. Our Provider Services Manager and Marketing Manager review this feedback and bring suggestions to relevant committees as part of our quality improvement process. In response to provider inquiries about how to access information, our Town Hall format now includes a review of the previous quarter's provider news notification items and a live demonstration of the resources available on our website.

Direct Feedback from Providers. In addition to these formal methods, we receive direct feedback from providers on network issues through ongoing interactions with Provider Relations Representatives, plan leadership, and through email on our Provider Portal.

"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. We are grateful for our long-standing partnership and look forward to expanding our mutual work in the future."

- Amy R. Behnke, J.D., Chief Executive Officer
Health Center Association of Nebraska

Utilizing Survey Results to Implement Quality Improvements. As noted, we review the Provider Satisfaction Survey results and create an action plan for the following year, prioritizing areas of improvement. We share the survey and the plan with the State annually.

The following are recent examples of items from our action plan. It is important to note that in the highlighted areas, our provider satisfaction scores are well above 80% and in some cases above 90% when including neutral through fully satisfied responses. Nebraska Total Care agrees with the State's plan to develop a uniform Provider Satisfaction Survey tool and methodology for all MCOs, and we will work as part of a team to adopt this survey. MLTC intends to promote clear positive or negative responses and avoid a neutral response category. Under this new method, we are confident that we will continue to lead the market in provider satisfaction.

Claims and Payment. This is the most fundamental interaction we have with our providers. The 2020 Provider Satisfaction Survey showed areas of opportunity amid challenges posed by the COVID-19 PHE. Under the direction of our COO and our Provider Services Manager, we made several configuration and benefit changes to our auto-adjudication procedures and required enhanced internal reporting from our Provider Relations Representatives and PSRs on disputes and resolutions.

In 2021, providers reported a marked improvement in their experience, as evidenced by a 25% or more improvement in ratings of above average for:

- Timeliness of claims payment
- Accuracy of claims payment
- Resolution of claims payment problems or disputes

In all of these categories, we consistently have a neutral or higher rating above 80%. Because there is always room for improvement in such a critical area, we keep this issue annually as a priority on our Provider Satisfaction Survey action plans. We perform ongoing configuration and benefits audits to improve auto-adjudication rates and accuracy.

Communications and Education. Our 2019 survey showed opportunities in two areas:

- Quality of provider orientations
- Quality of written communications, policy bulletins, and manuals

Our 2020 action plan tasked our COO with these improvements. We revised our provider orientation packet and provider communications, particularly our Town Hall meeting content and format. ***In the 2020 Provider Satisfaction Survey, we had a 95% improvement in the percentage of providers who rated us as above average in quality of orientations*** and a 45% improvement in providers who rated us above average in quality of written communications. Above-average responses in the number of specialists available increased by 40%, with neutral or better responses totaling 92%.

Collaborating with Other MCOs

The State encourages MCOs to work together to develop a uniform provider satisfaction tool. Nebraska Total Care has worked with MLTC and the other MCOs to develop a common set of Provider Satisfaction Survey questions for all Heritage Health MCOs that are included in all annual surveys. We welcome the opportunity to discuss methods of making the methodology and survey response data more uniform to provide a complete comparison of providers' experience with Nebraska Medicaid.

We have a history of working with the other MCOs to simplify administrative procedures, for example:

- We participated to create common forms for service authorizations for community-based BH services, such as Day Rehab, Community Support, Assertive Community Treatment, and Psychiatric Residential Treatment Facilities.
- We worked with other MCOs and additional stakeholders to create a universal PCP change form.
- We collaborated with MLTC and other MCOs to train providers on and implement the EAPG Outpatient Hospital reimbursement methodology.

Our Plan President and CEO, Heath Phillips, is the President of the Nebraska Association of Medicaid Health Plans. We will continue to communicate with CEOs, State leaders, providers, and provider associations to reduce their administrative burden and increase their satisfaction with Heritage Health.

RFP 112209 O3

Attachment B.43.A

2022 Q1 Provider Newsletter

Provider Report

Incentives for Pregnancy Notification

Start Smart for Your Baby (SSFB) is a case management program offered through Nebraska Total Care for our pregnant or NICU members. The goal is to improve maternal and infant health, including reducing pregnancy related complications, premature deliveries, low birth weight deliveries and infant disease. The SSFB program incorporates care management, care coordination, disease management, health education and additional support to pregnant or newborn members. Case managers who have experience in obstetric and neonatology will focus on providing assessment and education related to specific health conditions, pregnancy, healthy milestones of infant, prenatal and postpartum care, provider collaboration, and social determinates of health.

To encourage early identification of our pregnant members, we offer provider incentives to complete the Notification of Pregnancy (NOP). In addition to the Provider NOP incentives, we also offer member incentives starting in 2022, if the member completes the NOP within the 1st or 2nd trimester. Using NOPs and a risk stratification model of members, case managers can identify and outreach early to those members at greatest risk. By providing those members with the needed support, education and reducing barriers to care, we can improve both the mother and infant's quality of life. We strongly encourage providers to submit NOPs. The Notification of Pregnancy also gets the member into the Start Smart for Your Baby program.

Start Smart for Your Baby

The Start Smart for Your Baby Provider Notification of Pregnancy (NOP) (PDF) can be submitted through the Nebraska Total Care provider portal or via fax at 844 340 4888. Provider Incentives are based on timely submission of the NOP form and must be accurate and complete.

- 1st Trimester (0-14 weeks gestation): $100 incentive
- 2nd Trimester (15-28 weeks gestation): $40 incentive
- 3rd Trimester (29+ weeks gestation): $20 incentive

Nebraska Total Care also supports American College of Obstetricians and Gynecologists recommendations of progesterone usage on prematurity prevention, when appropriate and clinically indicated. Check the Nebraska Total Care website for incentive information.

Early intervention is essential to maximize a healthy pregnancy while minimizing potential complications. A Case Manager is available from 8:00 a.m. to 5 p.m. central time to assist with coordination of the member's healthcare needs.

The provider's role in Nebraska Total Care's Care Management program is extremely important. Practitioners who have identified a member who they think would benefit from disease or care management should contact the Care Management team at 1-844-385-2192 (TTY 711) or submit a referral request using the secure provider portal.

Comprehensive Diabetes Care

Per the Center for Disease Control and Prevention, diabetes, left unmanaged, can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death.

For providers, this means monitoring several factors. The HEDIS measure for comprehensive diabetes care, calculates the percentage of members, ages 18 to 75 who have type 1 or type 2 diabetes, and who have had the following tests/exams:

- Annual HbA1c
- HbA1c result <8 = in control
- Dilated Retinal Eye Exam
- Annual or prior year eye exam showing no evidence of retinopathy
- Controlled Blood Pressure
- Lower than 140/90 mm Hg

Many diabetic members are prescribed medication as part of their diabetes management. Medication review conducted year round is a critical component to prescribed treatment adherence and controlling chronic conditions, like diabetes. Take the time to review this process with each member – from explanation of medication options to filling the prescription. Providers can help members manage and control their glucose levels by also recommending lifestyle changes, such as eating a healthy diet, getting sufficient exercise and quitting smoking.

Nebraska Total Care offers access to disease management programs to help members learn more about their condition and manage it better. Disease management for members with diabetes focuses on glycemic control and monitoring for possible complications of the disease.

Members with diabetes have higher social needs on average. Helping to remove barriers and reduce isolation for members will have a positive impact on their overall health. Care Managers at Nebraska Total Care can also work with members to find additional community support.

Utilize the American Diabetes Association practice guidelines to review the updated components of diabetes care, general treatment goals, and tools to evaluate the quality of care.

Provider News Updates:

Visit our website to see posted provider news bulletins and sign up to receive provider emails about Nebraska Total Care benefits, operations, quality topics, and other important information.

Patient Documentation and Coding Tips

Conditions that go undocumented usually also go untreated. This is just one of the important reasons that thorough and accurate Risk Adjustment coding is critical to patient care. Additionally, comprehensive coding provides specialists and ancillary providers insight into a patient's complete health profile.

Please review the tips below to ensure that you are following the appropriate steps for accurate Risk Adjustment coding.

- Ensure the signature on the medical record (such as chart notes and progress notes) is legible and includes the signee's credentials.
- For Electronic Health Records, confirm all electronic signature, date, and time fields are completed. Include qualifying words such as "Authenticated by," "Verified by," or "Generated by."
- Make sure the physician documents to the highest degree of specificity in the medical record.
- Assign the ICD-10 code that includes the highest degree of specificity.
- Include proper causal or link language to support highest degree of specificity in diagnosis and coding.
- Verify that the billed diagnosis codes are consistent with the written description on the medical record.
- Include whether the diagnoses are being monitored, evaluated, assessed/addressed, and treated (MEAT) in the documentation.
- If a chronic condition is currently present in a member, do not use language such as "history of."
- On the medical record, document all chronic conditions present in the member during each visit.*
- At least once per year, submit all chronic diagnosis codes based on documentation in a claim.

*Your state may have specific criteria regarding the acceptable amount of codes allowable for submission. Please contact Nebraska Total Care for more information.

Care for Schizophrenia or Bipolar Disorder

Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): Assesses adults 18 years of age and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of the treatment period.

Heart disease and diabetes are among the top 10 leading causes of death in the United States. Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD): Assesses adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC): Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Learn more and see behavioral health practice guidelines.

HEDIS® Measures Performance

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures updated annually by the National Committee for Quality Assurance (NCQA).

Most health plans use HEDIS to measure performance on important aspects of care and service. Through HEDIS, NCQA holds Nebraska Total Care accountable for the timeliness and quality of healthcare services (including acute, preventive, mental health and other services). We also review HEDIS data to identify opportunities to improve rates and ensure our members are receiving appropriate care. Please familiarize yourself with the HEDIS topic below.

Nebraska Total Care's HEDIS scores can be found online in the Quality Improvement Evaluation.

Interoperability

Providers should have patient medical information and history in one place with the implementation of the Centers for Medicare and Medicaid Services (CMS) Interoperability Rule to enhance patients' control over their healthcare information. By ensuring that payers and providers are using common data formats and applications, this Rule allows information to be shared quickly and easily via third party applications that can be downloaded on a patient's phone. Providers' main focus should be:

- **Information Blocking Prevention:** Providers need to have policies and procedures in place to ensure information-blocking practices are prevented. These include any practices that interfere with the access, exchange or use of electronic health information (EHI).
- **Up-to-Date Digital Provider Information:** CMS now requires all individual healthcare providers and facilities to take immediate action to update their National Plan and Provider Enumeration System (NPPES) records online to add digital contact information. Providers should work with their electronic health record (EHR) vendors to ensure up-to-date digital information and current National Provider Identifier (NPI) is routinely updated.
- **COP Compliance:** The Interoperability Rule introduced a new Medicare Condition of Participation (COP) that requires all hospitals to send electronic notifications to a patient's healthcare providers (e.g., primary care practitioner) upon the patient's admission, discharge or transfer (ADT).

Providers are required to notify Nebraska Total Care of any relevant updates to their contact or credentialing information in a timely manner. Provider contact info is critical for our members, who depend on the accuracy of our Provider Directory.

Psychiatric Assistance Line

The Psychiatric Assistance Line (PAL) is a value-added service for providers interested in receiving non-emergent behavioral health clinical consultation. A psychiatrist is available to address questions for prescribers about psychotropic medication issues. Licensed Mental Health Professionals can assist with general mental health inquiries related to member care.

To access the PAL line, please call Nebraska Total Care at 1-844-385-2192 (Relay 711). Select "2" for Providers, then "3" for Authorizations, then "2" for Mental Health Services. Ask for the "PAL Line".

Guidelines for Care

Nebraska Total Care adopts preventive and clinical practice guidelines based on the health needs of our membership and on opportunities for improvement identified as part of the quality improvement (QI) program.

When possible, we adopt preventive and clinical practice guidelines formulated by nationally recognized organizations, government institutions, statewide initiatives or a consensus of healthcare professionals in the applicable field.

Guidelines are available for preventive services, as well as for the management of chronic diseases, to assist in developing treatment plans for members and to help them make healthcare decisions. Nebraska Total Care evaluates providers' adherence to the guidelines at least annually, primarily through monitoring of relevant HEDIS measures.

The guidelines:

- Consider the needs of the members
- Are adopted in consultation with network providers
- Are reviewed and updated periodically, as appropriate
- Are intended to augment, not replace, sound clinical judgment

Preventive and chronic disease guidelines and recommendations include:

- Adult, adolescent and pediatric preventive care guidelines
- Guidelines for diagnosis and treatment of ADHD, asthma, depression, diabetes, hypertension and other diseases and disorders

For the most up-to-date preventive and clinical practice guidelines or to review our clinical and payment policies (behavioral health, physical health, pharmacy), go to NebraskaTotalCare.com or call 1-844-385-2192, Nebraska Relay Service 711.

Access to Care Management

Do you have patients whose conditions need complex, coordinated care they may not be able to facilitate on their own? A care manager may be able to help.

Care managers are advocates, coordinators, organizers and communicators. They are trained nurses and other clinicians who promote quality, cost-effective outcomes by supporting you and your staff, as well as your patients and their caregivers.

A care manager connects the Nebraska Total Care member with the healthcare team by providing a communication link between the member, his or her primary care physician, the member's family and other healthcare providers, such as physical therapists and specialty physicians.

Care managers do not provide hands-on care, diagnose conditions or prescribe medication. Care managers help members understand the benefits of following a treatment plan and the consequences of not following the plan outlined by a physician. Our team is here to help your team with:

- Non-compliant members
- Communication with PCP
- High-risk pregnancy
- New diagnoses
- Chronic care
- Disease management
- Complex multiple co-morbidities
- Continuity of care

Community Health Service Representatives (CHSRs) provide diabetes health coaching for adult type II diabetic members and perinatal coaching for expecting mothers. Both of these health coaching programs offer educational topics, support, resources for self-management skills and life style change, as well as assistance with bridging gaps in social determinants of health. CHSRs typically go to member's homes to provide services and hopefully they will be able to resume that in the near future. Nebraska Total Care has CHSRs located in Omaha, Lincoln and the Kearney/Grand Island area.

Members may benefit from additional resources, such as the Krames Staywell Health Library, the myStrength well-being app, and Nebraska 211. Our findhelp resource tool connects members with local programs and supports. These programs provide help with food, shelter, healthcare, money and education, jobs and more.

Providers can directly refer members to our care management program by phone or through the provider portal. Providers may call 1-844-385-2192 (Relay 711) for additional information about the care management services Nebraska Total Care offers.

Provider Services: 1-844-385-2192, Nebraska Relay Service 711
Provider Relations: NEProviderRelations@NebraskaTotalCare.com
Contracting: NetworkManagement@NebraskaTotalCare.com

Mailing Address:
Nebraska Total Care
Attn: Provider Relations
2525 N 117th Ave, Suite 100
Omaha, NE 68164-9988

Claims Address:
Nebraska Total Care
Attn: Claims
PO Box 5060
Farmington, MO 63640-5060

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Attachment B.43.B

2022 Provider Billing Guide

2022 Provider Billing Guide

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Introductory Billing Information

Billing Instructions

Nebraska Total Care follows the Centers for Medicare and Medicaid Services (CMS) rules and regulations for billing and reimbursement.

The billing, claims and payment information identified in this guide are applicable to both Nebraska Medicaid and Long-Term Care populations: Heritage Health (HH) and Heritage Health Adult (HHA) Expansion population.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Nebraska Total Care for payment of covered services.

It is important that providers ensure Nebraska Total Care has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Medicaid Number
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24J. We encourage our providers to bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the required data will be rejected, and a notice sent to the provider, creating payment delays.

We recommend that providers notify Nebraska Total Care 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form to NetworkManagement@NebraskaTotalCare.com. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member must be effective on the date of service (see information below on identifying the member)
- The service provided must be a covered benefit under the member's contract on the date of service
- Referral and prior authorization processes must be followed, if applicable, using the NebraskaTotalCare.com prior authorization "Pre-Auth" check tool online.

Payment for service is contingent upon compliance with payment policies and procedures, as well as the billing guidelines outlined in this manual. When submitting your claim, you need to identify the member. There are two ways to identify the member:

- The member number found on the member ID card or the provider portal.
- The Medicaid Number provided by the State and found on the member ID card or the provider portal.

Claim Forms

Nebraska Total Care only accepts the CMS-1500 (2/12) and CMS-1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS-1500 (2/12) form and institutional providers complete the CMS-1450 (UB-04) claim form. Nebraska Total Care does not supply claim forms to providers. All paper claim forms are required to be typed or printed and in the original red and white version to ensure clean acceptance and processing. All claims with handwritten information or on black and white forms will be rejected, with the exception of Box 31 on HCFA 1500, Nebraska Total Care will allow a Provider Signature, but it must be within box 31, if outside box claim will reject. If you have questions regarding what type of form to complete, contact Nebraska Total Care at 877-600-5472.

Billing Codes

Nebraska Total Care requires claims to be submitted using codes from the current version of, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the member
- Diagnosis code is missing digits
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Medical Documentation, itemized statements, and invoices may be required for non-specific types of claims or at the request of Nebraska Total Care. Invoices will be required on unlisted or miscellaneous codes.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Use of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Clean Claim Definition

A clean claim means a claim received by Nebraska Total Care for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Nebraska Total Care.

Rejection Versus Denial

All claims must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected.

REJECTION: A list of common upfront rejections can be found listed below (See section titled Common Causes of Upfront Rejections). Rejections will not enter our claims adjudication system, so there will be no explanation of payment (EOP). A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. For paper claim submissions that reject the provider will receive a letter identifying the rejection reason and for electronic claims submissions a rejection report is generated with the rejection reason codes.

DENIAL: If all minimum edits pass the claim is accepted and it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A comprehensive list of common delays and denials can be found below (See section titled Common Causes of Claims Processing Delays and Denials).

Claim Payment

Claims Check Run for Nebraska Total Care Claims:

- Finalized claims for Nebraska Total Care providers will be paid every Tuesday and Friday on the weekly check runs. Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
- 90% within 10 business days of the receipt
- 99% within 60 business days of the receipt

Claims Interest: Nebraska Total Care will pay providers interest at an annualized rate of 12%, for the full period in which a payable clean claim remains un-adjudicated beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated.

Contacts for Nebraska Total Care:

Plan Address/Administrative Office:

Nebraska Total Care
2525 N. 117th Ave, Suite 100
Omaha, NE 68164
(Please do not submit any claims/reconsiderations/appeals to this address)

Claims Submission/Reconsiderations/Appeals Address:

Nebraska Total Care
Attn: Claims
PO Box 5060
Farmington, MO 63640-5060

Claims Refund Address:

Nebraska Total Care
Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713

Customer Service (Provider and Member Services):

Toll Free: 1-844-385-2192
Nebraska Relay Service 711

Claims Payment Information

Claims for Long-Term Care Facilities

Long-Term Care facilities are required to bill on a UB-04 claim form for all inpatient (inpatient bill type) and outpatient services (outpatient bill type). Please verify authorization at NebraskaTotalCare.com using the Pre-Auth Check Tools. Room and board for long-term members is managed by the State of Nebraska at the per diem rate at this time. Short-term acute stays are a covered benefit by Nebraska Total Care. Room and board and outpatient services are covered by Nebraska Total Care. Room and board will pay off State assigned per diem rate. Outpatient services such as DME, PT/OT/ST will pay off of Nebraska Medicaid Fee Schedules. Prior authorization is required for skilled inpatient services on an IP authorization form. DME and PT/OT/ST require authorization on an OP authorization form. Please verify using the NebraskaTotalCare.com website Pre-Auth Check Tools to see which services require authorization. When submitting claims for short-term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short-term stay. We utilize Revenue codes 110179 for Skilled Room and Board.

Electronic Claims Submission

Network providers are encouraged to participate in Nebraska Total Care's electronic claims/encounter filing program. Nebraska Total Care can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims.

In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Nebraska Total Care's Payor ID for Physical and Behavioral Health is 68069. Our Clearinghouse vendors include Change Healthcare (formerly Emdeon), Envoy, WebMD and Gateway EDI. For questions or more information on electronic filing, please contact:

Nebraska Total Care
C/O Centene EDI Department
1-800-225-2573, ext. 6075525
Fax: 866-266-6985 or E-mail: EDIBA@centene.com

Paper Claim Submission

For Nebraska Total Care members, all claims and encounters should be submitted to:

Nebraska Total Care
Attn: Claims Department
PO Box 5060
Farmington, MO 63640-5060

Requirements

Nebraska Total Care uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable. Note: Nebraska Total Care is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form (CMS-1500 or UB-04)

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't utilize staples for attachments or multi page documents

Basic Guidelines for Completing CMS-1500 Claim Form (Instructions in Appendix):

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

Electronic Funds Transfers (EFT) & Electronic Remittance Advices (ERA)

Nebraska Total Care provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straightforward reconciliation of payments. As a provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re- keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily
- Receive payment and remittance advice quicker by registering with Payspan. Payspan is a free multi-payor solution. To sign up, call 1-877-331-7154 or email Payspan at ProviderSupport@PayspanHealth.com.

EFT/ERA Information

For more information on our EFT and ERA services, please contact:

Nebraska Total Care
Provider Services Department
1-844-385-2192, Nebraska Relay Service 711

Payspan
1-877-331-7154
PayspanHealth.com

Common Causes of Claims Processing Delays & Denials

- Incorrect Form Type
- Diagnosis Code Missing Digits
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Member ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third Party Liability Information

Nebraska Total Care will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Causes of Up Front Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim

- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Claims submitted with handwritten data or black and white forms

Nebraska Total Care will send providers a letter or report for each claim that is rejected explaining the cause for the rejection.

CLIA Accreditation

Labs who participate in the Medicare or Medicaid sector of Nebraska Total Care must be CLIA accredited. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB) located at jcrinc.com/store/publications/manuals/.

How to Submit a CLIA Claim

Via Paper

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number for those laboratory services for which CLIA certification or waiver is required.

*Note - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Via EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

**Note* - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the referring laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different then information provided in loop 2310C. The 2420C would contain Laboratory name and NPI.

Via Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

*Note - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the referring laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Claim Reconsideration Requests & Corrected Claims

All claim requests for reconsideration and corrected claims must be received within 90 calendar days from the date of the Explanation of Payment (EOP). If a provider has a question or is not satisfied with the information they have received related to a claim they may reach out to Nebraska Total Care in the following ways:

- Contact a Nebraska Total Care Provider Service Representative at 1-844-385-2192, Nebraska Relay Service 711. Providers may discuss questions with Nebraska Total Care Provider Services Representatives regarding amount reimbursed or denial of a particular service.
- Contact the assigned Provider Relations Representative assigned to your facility/organization.

- Submit an adjusted or corrected claim via the provider portal or in writing to Nebraska Total Care, Attn: Claims, PO Box 5060, Farmington, MO 63640-5060. The claim must include the original claim number in field 22 of a CMS-1500 or field 64 of the UB-04. Failure to include the original claim number and frequency code may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.
- Submit a claim reconsideration request in writing using the Reconsideration Form with supporting documentation via mail to: Attn: Claim Reconsiderations, PO Box 5060, Farmington, MO 63640-5060

Nebraska Total Care shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 30 calendar days of receipt of the corrected claim, request for reconsideration or claim dispute. Below are the different reconsideration situations.

- First time disputing a payment/denial of a claim
- Provider has disputed payment/denial of the claim once before but has now made changes to their billing
- Dispute changes due to a change in denial/status of the claim

Claim Appeal

In order to file a claim appeal the provider MUST have received an unsatisfactory response to a request for claim reconsideration. Submit the following items when filing a claim appeal within 60 days of the adjudication date:

- Claim Appeal Form
- Original Request for Reconsideration letter and response
- Any supporting documentation supporting the appeal

Mail your Claim Appeal Form and all other attachments to:

Nebraska Total Care
Attn: Claim Appeal
PO Box 5060
Farmington, MO 63640-5060

Nebraska Total Care shall process, and finalize claim appeals within 30 calendar days of receipt of the claim appeal.

If a provider's submission of a corrected claim, request for reconsideration or claim appeal results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for next level appeal.

Provider Refunds

When a provider sends a refund for claims processed, the refund must be sent to the following address:

Nebraska Total Care
Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713

Third Party Liability / Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

Nebraska Total Care is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Nebraska Total Care members. If a member has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a member with insurance primary to Medicaid, the claim will deny until this information is received. If a member has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

Billing the Member / Member Acknowledgement Statement

Nebraska Total Care reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usually 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.

In order 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 written acknowledgment following this language (the Member Acknowledgement Statement):

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that Nebraska Total Care through its contract with the Nebraska Department of Healthcare and Family Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Nebraska Total Care Code Auditing & Editing

Nebraska Total Care uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding "rule." When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios.

Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios that justify payment above and beyond the basic service performed.

Moreover, Nebraska Total Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

Level I HCPCS Codes (CPT): This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

Level II HCPCS: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

Miscellaneous/Unlisted Codes: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office

notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

- **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
- **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD 10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems. On UB 1450 claim form, providers must fill out 74 A-E for Inpatient only. Outpatient services require Revenue codes and HCPCS/CPT code combinations.

Revenue Codes

These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Code Auditing & Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code auditing cycle, each service line on the claim is processed through the code auditing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Code Auditing Principles

The below principles do not represent an all-inclusive list of the available code auditing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

CMS National Correct Coding Initiative-
cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column One/Column Two edits. The Column One procedure code is the most comprehensive code and reimbursement for the Column Two code is subsumed into the payment for the comprehensive code. The Column One code is considered an integral component of the Column Two code.

The CMS NCCI edits consist of procedure to procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the Column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. Practitioner PTP Edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The Hospital PTP Edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Edit Table

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0 or 10 day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with “MMM - Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member’s lifetime. State fee schedules also delineate the number of

times a procedure can be billed over a given period of time or during a member's lifetime (Nebraska Example: 60 combined PT/OT/ST therapy units for adults in one year; 12 chiropractic visits in one calendar year).

Duplicate Edits

Code auditing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same member on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis. 80 and AS will be accepted.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add- on code should have been used to describe the additional services rendered.

Bilateral Edits

Enter the appropriate CPT procedure code with modifier "50" on a single line of service. Enter ONE CHARGE in field 24F ($ charges). Enter "1" in field 24G (days or units).

Administrative & Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- **Procedure code invalid rules**: Evaluates claims for invalid procedure and revenue or diagnosis codes
- **Deleted codes:** Evaluates claims for procedure codes which have been deleted
- **Modifier to procedure code validation: I**dentifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- **Age Rules: I**dentifies procedures inconsistent with member's age
- **Gender procedure: I**dentifies procedures inconsistent with member's gender
- **Gender diagnosis: I**dentifies diagnosis codes inconsistent with member's gender
- **Incomplete/invalid diagnosis codes:** Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Nebraska Total Care's clinical validation services is modifier -25 and -59 review.

When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). Nebraska Total Care's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

MODIFIER -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Nebraska Total Care uses the following guidelines to determine if modifier -59 was used correctly.

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas, which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier -59 were used appropriately.

MODIFIER -25

Both CPT and CMS specify in the NCCI policy manual that by using a modifier -25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service". Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E/M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Nebraska Total Care uses the following guidelines to determine whether or not modifier -25 was used appropriately.

If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment & Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations Related to Code Auditing and Editing

Claims appeals resulting from claim-editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code audit or edit and request claim reconsideration, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

Nebraska Total Care follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting & Non-Payment for Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Nebraska Total Care for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

Non-Payment & Reporting Requirements Provider Preventable Conditions (PPCs) - Inpatient

Nebraska Total Care follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, the health plan follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim.

Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. Nebraska Total Care follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive surgery performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Non-Payment & Reporting Requirements Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

Lesser of Language

Unless specifically contracted otherwise, Nebraska Total Care's policy is to pay the lesser of billed charges and negotiated rate.

- Example 1 – Code 12345 – Billed $600. Negotiated Rate is $500. Nebraska Total Care pays $500 negotiated rate.
- Example 2 – Code 12345 – Billed $500. Negotiated Rate is $600. Nebraska Total Care pays $500 billed rate.

Timely Filing

Providers must submit all claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Nebraska Total Care, up to a maximum of 180 calendar days. When Nebraska Total Care is the secondary payer, claims must be received within 365 calendar days of the date of service.

All claim requests for reconsideration or corrected claims must be received within 90 calendar days from the date of notification of payment or denial. Claims appeals must be received within 60 calendar days from the date of notification of payment or denial is issued.

Use of Assistant Surgeons

An Assistant Surgeon is defined as a physician who utilizes professional skills to assist the Primary Surgeon on a specific procedure. All Assistant Surgeon's procedures are subject to retrospective review for Medical Necessity by Medical Management. All Assistant Surgeon's procedures are subject to health plan policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

Additional Billing Information

Hospice

Hospice services are billed to Nebraska Total Care on Form CMS-1450, Health Insurance Claim Form.

Type of Bill Required

Valid hospice bill types = 81_ and 82-_

For hospice services, Nebraska Total Care allows the following revenue codes:

- 651 - Routine Home Care
- 652 - Continuous Home Care
- 655 - Inpatient Respite Care
- 656 - General Inpatient Care

*Note: No other revenue codes are accepted.

The revenue codes must be billed with the appropriate corresponding HCPC as follows:

- T2042- Routine Home Care
- T2043 - Continuous Home Care
- T2044 - Inpatient Respite Care
- T2045 - General Inpatient Care

*Note: No other procedure codes are accepted. Only one procedure code per day may be billed. For further clarification review Nebraska Medicaid regulations in section 471-36-000 and Appendix 471-000-81.

Obstetrics Billing

Global OB Care

The total obstetric care package includes the provision of antepartum care, delivery services and postpartum care. When the same group physician and/or other health care professional provides all components of the OB package, report the Global OB package code.

The CPT for Global OB codes are:

- 59400 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59610 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Billing Guidelines

The global maternity allowance is a complete, one-time billing, which includes all professional services for routine antepartum care, delivery services and postpartum care. The fee is

reimbursed for all of the member's obstetric care to one provider. If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery and performs the postpartum care, then the provider must bill the Global OB code. Global OB care should be billed on or after the delivery date.

Non-global OB care

Non-global OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for non-global re may occur if:

- A patient transfers into or out of a physician or group practice
- A patient is referred to another physician during her pregnancy
- A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice
- A patient terminates or miscarries her pregnancy
- A patient changes insurers during her pregnancy

Billing Guidelines

Antepartum care only reporting:

- If only one to three antepartum visits were provided, report the appropriate E/M codes, according to CPT® guidelines.
- If four to six visits are provided, report 59425 antepartum care only.
- If seven or more visits are provided, report 59426 antepartum care only.
- Each date of service should be billed with one (1) unit per date.
- The dates reported should be the range of time covered. Example: If the patient had a total of 4-6 antepartum visits, then the physician should report CPT code 59425 with from and to dates for which the services occurred.
- CPT 59425 and 59426 – These codes must not be billed together by the same provider for the same beneficiary, during the same pregnancy.
- Pregnancy related E/M office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same beneficiary, during the same pregnancy.

Reimbursement to FQHCs and RHCs

Nebraska Total Care will reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34. Nebraska Total Care will not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

If Nebraska Total Care is unable to contract with an FQHC or RHC within PCP access distance standards provided by MLTC, Nebraska Total Care is not required to reimburse that FQHC or RHC for out-of-network services without prior approval unless:

- The medically necessary services are required to treat an emergency medical condition.
- FQHC/RHC services are not available through a minimum of one (1) MCO within MLTC's established travel standards.

Nebraska Total Care may stipulate that reimbursement is contingent on receiving a clean claim and all medical information required to update the member's medical record.

Referring/Ordering Physician Requirements

When submitting professional service claims for PT/OT/ST, DME and Hearing Aid services on HCFA 1500 forms, the Nebraska Medicaid regulatory billing guidance requires the identification of the referring/ordering physician on the claim form (Box 17 on a HCFA 1500).

This guidance does not apply to these services when they are billed for a facility on a UB-04 claim form.

The Nebraska Administrative Code (NAC) regulatory billing instructions referencing these requirements can be found by clicking on the following:

- DME Chapter 471 Billing Instructions
- Hearing Aid Chapter 471 Billing Instructions
- PT/OT/ST Chapter 471 Billing Instructions

EAPG

Effective January 1, 2020, Nebraska Total Care will move to acuity based reimbursement, in line with guidance from Nebraska Medicaid and Long-Term Care, for outpatient hospital services using Enhanced Ambulatory Patient Groups (EAPG) methodology. This updated payment approach will not apply to Critical Access Hospitals (CAH's). EAPG is an outpatient visit-based patient classification system designed by 3M and assigns a classification to each claim detail line (574 EAPG's under version 3.14 that will be utilized at implementation).

The base EAPG rates can be viewed on the DHHS website.

There will be no changes in billing hospital outpatient service claims to Nebraska Total Care. All current billing guidelines will continue to be followed for claim submission:

- EAPG payments are made on a per visit basis
- Payment is directed to the main significant procedure or treatment provided during an outpatient visit
- Payment for the main significant procedure considers the average cost of associated ancillary services
- Methodology uses packaging and bundling of payment for related services to create incentives that are consistent with providing services in the most efficient way
- Payment is concentrated on the main procedure, rather than diluting the payment across multiple ancillary services
- It is possible for multiple EAPG payments to be made for the same visit

Appendix I: Instructions for Supplemental Information

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS-1500 (2/12) form field 24A-G:

- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs (Note: all providers must submit NDC data even if they hold 340b status.
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Codes (NDC)
- CTR Contract Rate

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- GR Gram
- ME Milligram
- ML Milliliter
- UN Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three (3) blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached														NPI	
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix II: Instructions for Submitting NDC Information

Instructions for Entering the NDC

Use the guidelines noted below for all claim types including Web Portal submission. All providers must submit NDC data, even if they hold 340b status. CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

Table - 837I/837P

837I/837P Data Element	Loop	Segment/Element
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

For Electronic submissions, this is highly recommended and will enhance claim reporting/ adjudication processes, report in the LIN segment of Loop ID-2410.

Table - Paper Claim Type

Paper Claim Type	Field
CMS-1500 (02/12)	24 A (shaded claim line)
UB-04	43

Facility

Paper, use Form Locator 43 of the CMS-1450 and UB-04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250-259 and 634-636.

Physician

Paper, use the red shaded detail of 24A on the CMS-1500 line detail.

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code. The middle four digits are the product code. The last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:

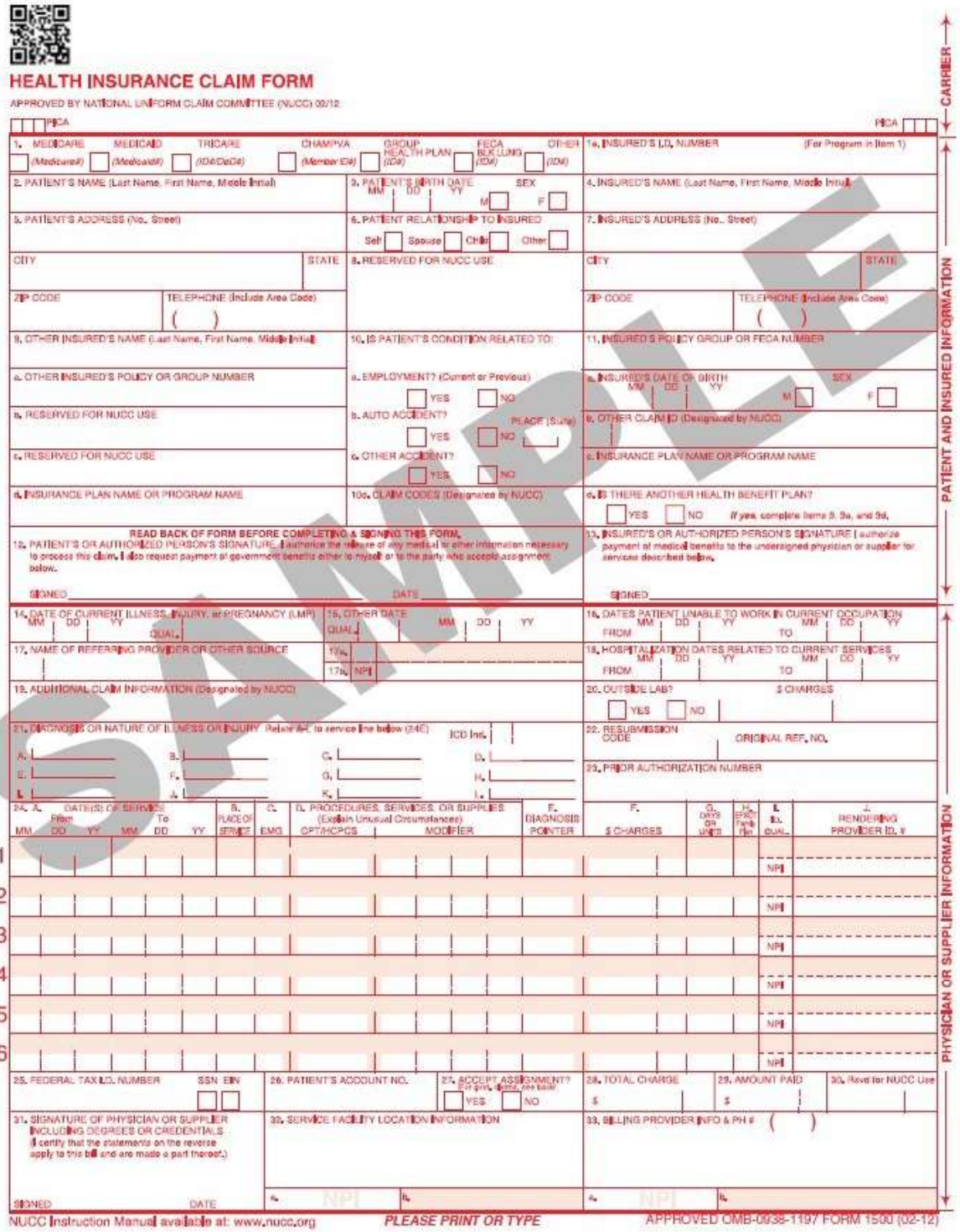
- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit
- For a 5-4-1 digit number, add a 0 as the tenth digit

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

- F2 - International Unit
- GR -Gram
- ML - Milliliter
- ME - Milligram
- UN – Unit

Appendix III: CMS-1500 Claims Form Instructions

CMS-1500 (2/12) Claim Form Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CMS-1500 (2/12) Claim Form Field Descriptions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

Table - CMS-1500 Form Field Instructions

Field #	Field Description	Instructions or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other."	R
1a	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's Nebraska I.D. Card	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Nebraska I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Nebraska I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C

Field #	Field Description	Instructions or Comments	Required or Conditional
15	OTHER DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported. 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation (This is for property and causality only)	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). *This field is required for PT/OT/ST/DME/Hearing Aid service claims	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used. *This field is required for PT/OT/ST/DME/Hearing Aid service claims	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C

Field #	Field Description	Instructions or Comments	Required or Conditional
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims missing or with invalid diagnosis codes will be rejected or denied for payment. Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM	R
22	RESUBMISSION CODE / ORIGINAL REF. NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j	GENERAL INFORMATION	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. **(continued on next page)**	

Field #	Field Description	Instructions or Comments	Required or Conditional
24a-j (continued)	GENERAL INFORMATION (continued)	The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.	
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix III of this guide.	C
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM|DD|YYYY). If there is only one date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24 D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should be listed first; other applicable services should follow. The reference letter(s) should be A–L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied. This field allows for the entry of 4 characters in the unshaded area.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar R sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy, Use G2 qualifier for ID, if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Nebraska recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Nebraska. Nebraska programs are always the payers of last resort.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Nebraska. Nebraska programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. **Note:** Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier ID (no spaces).	C

Field #	Field Description	Instructions or Comments	Required or Conditional
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

Appendix IV – UB-04 Claims Form Instructions

Completing a UB-04 Claim Form

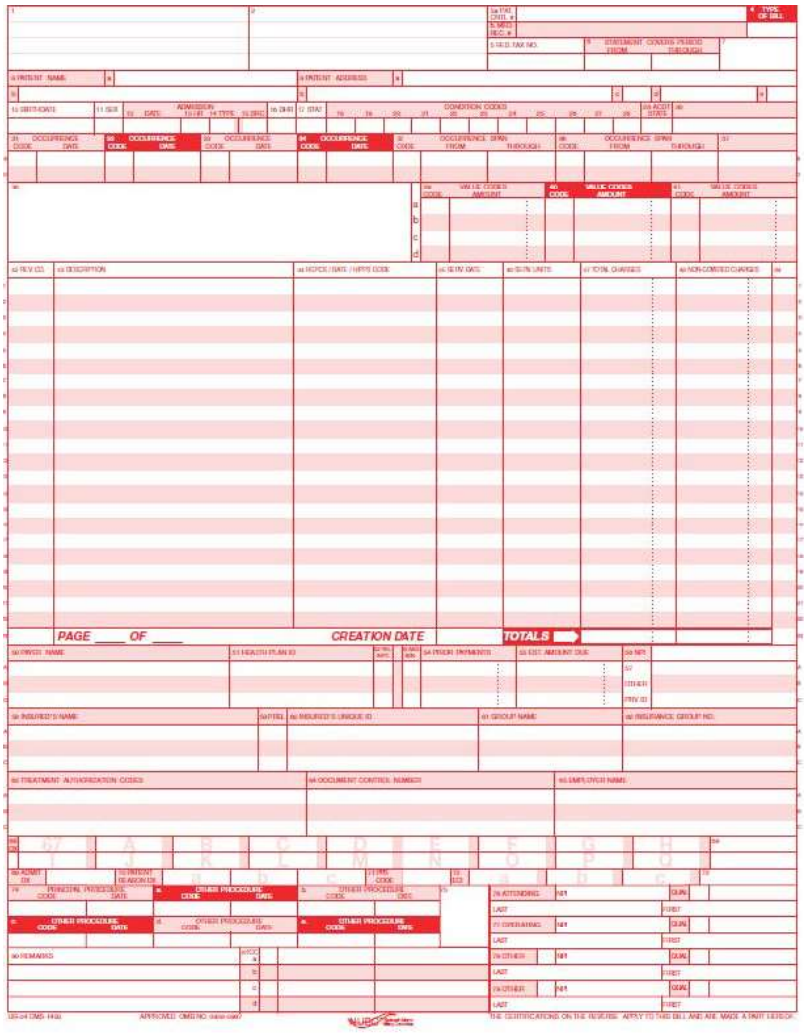
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Nebraska. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

Professional fees must be billed on a CMS-1500 claim form. Include the appropriate CPT code next to each revenue code. Please refer to your provider contract with Nebraska or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example



UB-04 Claim Form Field Descriptions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

Table - UB-04 Form Field Instructions

Field #	Field Description	Instructions or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/ THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not Used.	Not Required
8a	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member’s Nebraska I.D. card	Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
8b	PATIENT NAME	8b – Enter the patient's last name, first name, and middle initial as it appears on the Nebraska ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	R
9	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R
13	ADMISSION HOUR	Enter the time using 2 digit military times (00-23). 00- 12:00 midnight to 12:59 01- 01:00 to 01:59 02- 02:00 to 02:59 03- 03:00 to 03:39 04- 04:00 to 04:59 05- 05:00 to 05:59 06- 06:00 to 06:59 07- 07:00 to 07:59 08- 08:00 to 08:59 09- 09:00 to 09:59 10- 10:00 to 10:59 11- 11:00 to 11:59 **(continued on next page)**	R

Field #	Field Description	Instructions or Comments	Required or Conditional
13 (continued)	ADMISSION HOUR (continued)	12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1- digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room 7 Court/Law Enforcement 8 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R

Field #	Field Description	Instructions or Comments	Required or Conditional
16	DISCHARGE HOUR	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 00- 12:00 midnight to 12:59 01- 01:00 to 01:59 02- 02:00 to 02:59 03- 03:00 to 03:39 04- 04:00 to 04:59 05- 05:00 to 05:59 06- 06:00 to 06:59 07- 07:00 to 07:59 08- 08:00 to 08:59 09- 09:00 to 09:59 10- 10:00 to 10:59 11- 11:00 to 11:59 12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover **(continued on next page)**	R

Field #	Field Description	Instructions or Comments	Required or Conditional
17 (continued)	PATIENT STATUS (continued)	30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long¬term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	R
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	Not Used.	Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
31-34 a-b	OCCURRENCE CODE and OCCURRENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	UNLABELED FIELD	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
39-41 a-d	VALUE CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
42-47 General Information Fields	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	Rev CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
43 Line 23	PAGE__OF__	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	UNLABELED FIELD	Not Used.	Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Nebraska is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Nebraska Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of “7” (Replacement of Prior Claim) or Type of Bill. Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1&3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" and most “V” codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR	Report the applicable POA indicator (Y, N, U, or W) for the principal diagnosis and any secondary diagnoses as the eighth digit.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes and most “V” are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry; field’s 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes and most “V” are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE	This field is required to be completed when there is a primary trauma diagnosis on the claim.	C
73	UNLABELED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

Field #	Field Description	Instructions or Comments	Required or Conditional
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABELED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the R patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider. ZZ – Other Operating MD. 82 – Rendering Provider. NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R

RFP 112209 O3

Attachment B.43.C
Town Hall Presentation

Provider Town Hall

March 2022

3/31/2022

Agenda

- Introduction
- Key Updates: Known Issue Log
- Provider News
- Physical Health Provider Relations
- Network Management
- Public Facing Website
- Provider News
- Claim Reconsiderations/Appeals
- Web Portal
    - Provider Analytics 2.0
- Integrated Case Management
- Behavioral Health

Customer Service

Phone Number

1-844-385-2192

TDD/TTY: 1-844-307-0342

Website

NebraskaTotalCare.com

Email

NEProviderRelations@NebraskaTotalCare.com

NetworkManagement@NebraskaTotalcare.com

Provider Relations Team

Physical Health Provider Relations

General Provider Relations Inquiries
NEProviderRelations@NebraskaTotalCare.com

Tim Easton
Sr. Director, Contracting and Network Development
Timothy.Easton@NebraskaTotalCare.com
Cell: 402-594-6817

Jennifer Newcombe
Tribal Liaison & FQHC Representative
Jennifer.L.Newcombe@NebraskaTotalCare.com
Office: 531-329-8583
Cell: 402-206-3475

Dan Good
CHI/Uninet Owned and Independent Statewide
Daniel.E.Good@NebraskaTotalCare.com
Office: 531-329-8552
Cell: 531-215-3324

Monique Pridgeon
Internal Rep Supporting Total Respiratory, Methodist Owned and Independent Providers, Boys Town, Children's Hospital
Monique.L.Pridgeon@NebraskaTotalCare.com
Office: 531-329-8553

Physical Health Regions

What can my Provider Relations Representative do for me?

Provider Education

Data Analytics Tool Training and Support

HEDIS/Care Gap Reviews

Claims Analysis

Facilitating with Inquiries related to administrative policies, procedures and operational issues

Monitoring performance patterns

Assisting in Provider Portal registration and Payspan

Provider Relations Contact List: Physical Health PR Map

Contact Provider Relations at NEProviderRelations@NebraskaTotalCare.com

What can Network Management do for me?

Roster updates

Adds, including roster or Provider Data Form

Term provider

Address changes (W9 required) including licensure changes

Credentialing Updates

Demographic Updates

Self Service Practice Management: Provider Practice Updates

Contact Network Management at NetworkManagement@NebraskaTotalcare.com

Network Management Map

Tim Easton
Sr. Director, Contracting & Network Development
Timothy.Easton@NebraskaTotalCare.com
Cell: 402-594-6817

Pharmacy Providers
Envolve Pharmacy
800-974-5268

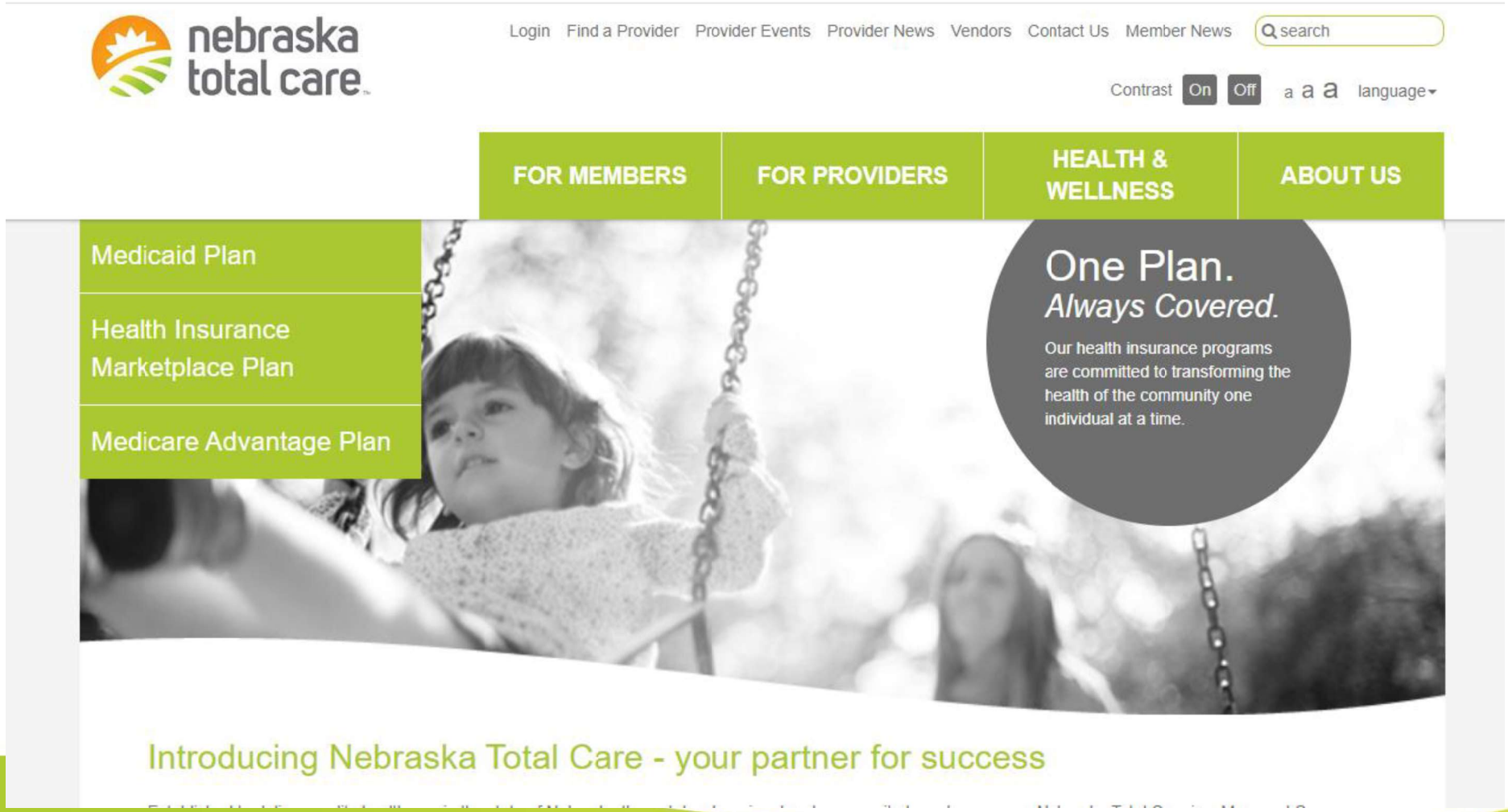
Routine Vision Providers
Envolve Vision
New contract requests:
ProviderContracts@EnvolveHealth.com
Existing provider inquiries:
Envolve_AdvancedCaseUnit@EnvolveHealth.com
800-531-2818

CONTRACT NEGOTIATORS

AREA 1 - Michelle Haywood
402-401-4876
Michelle.L.Haywood@NebraskaTotalCare.com

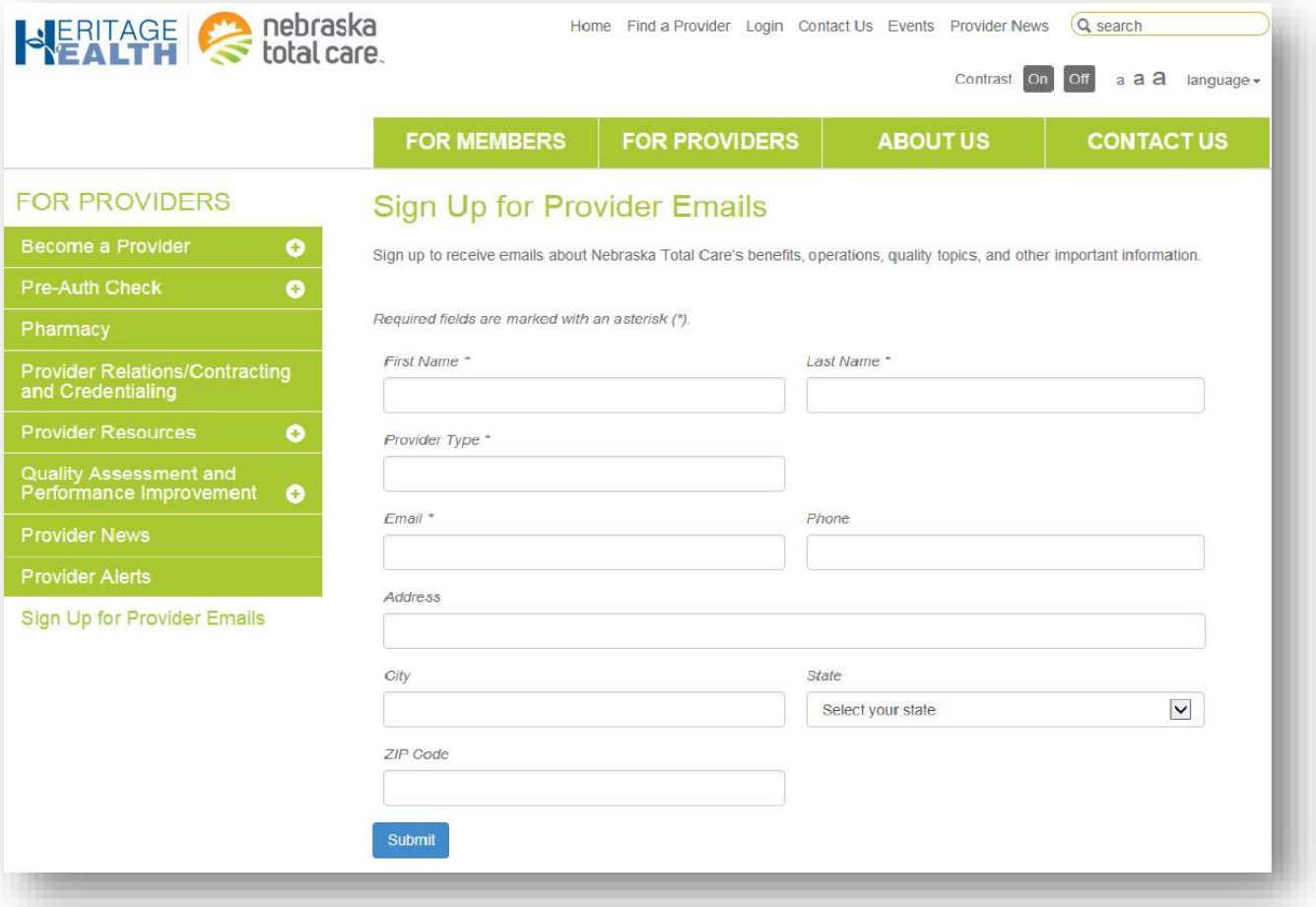
AREA 2 - Nic Zajac
531-329-8536
Nicholas.M.Zajac@NebraskaTotalCare.com

Public facing website

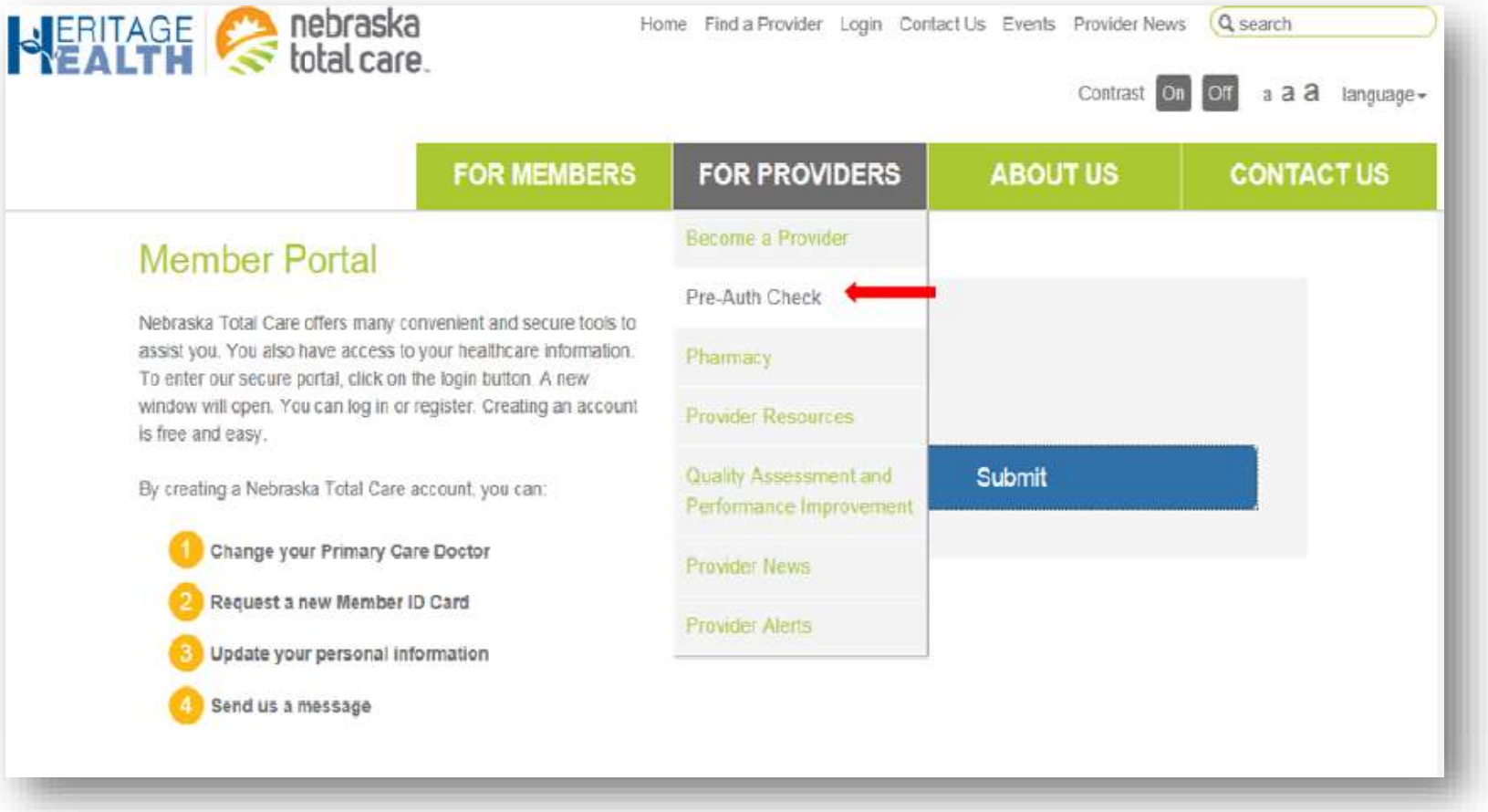


Email notifications

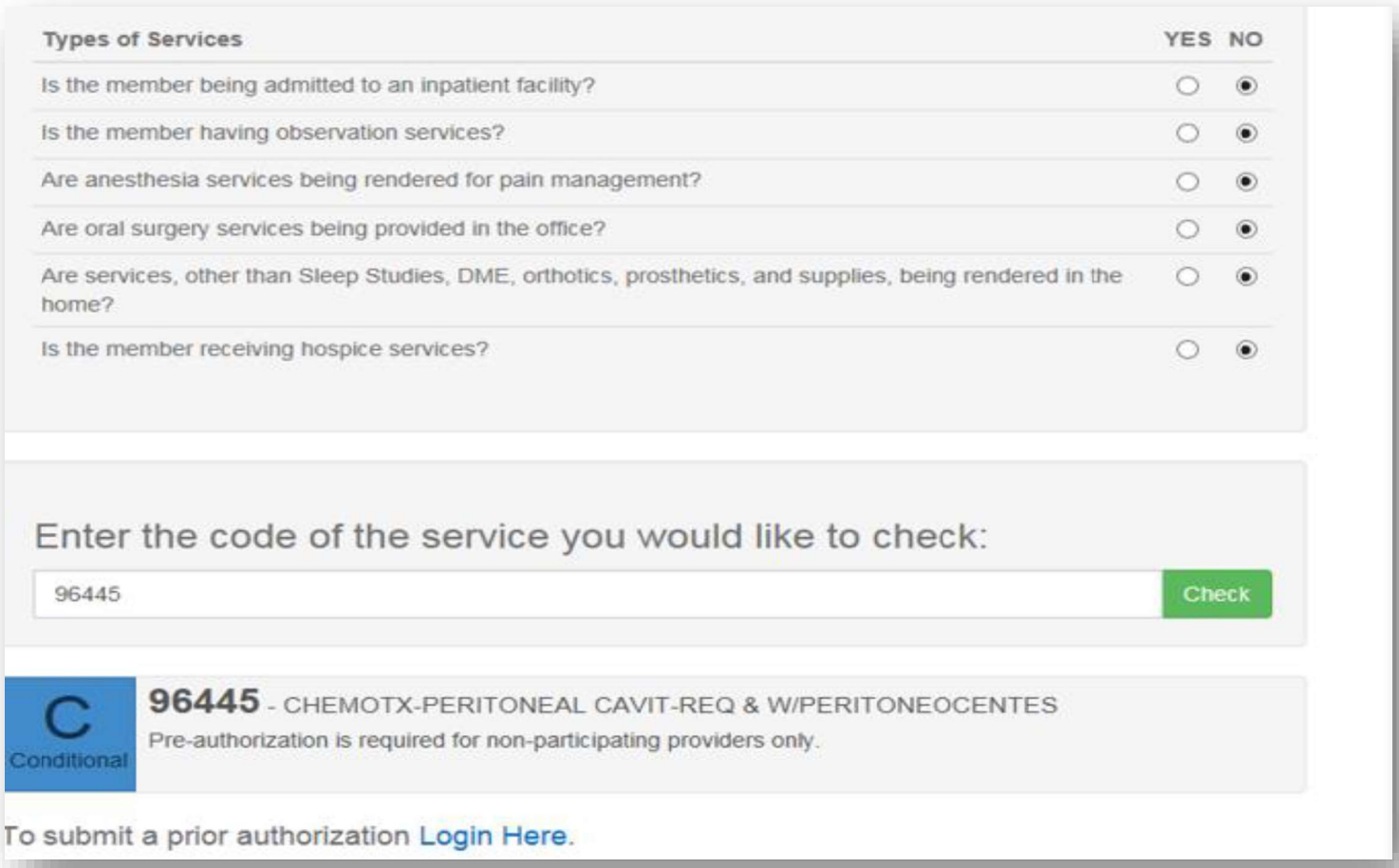
Sign up for emails



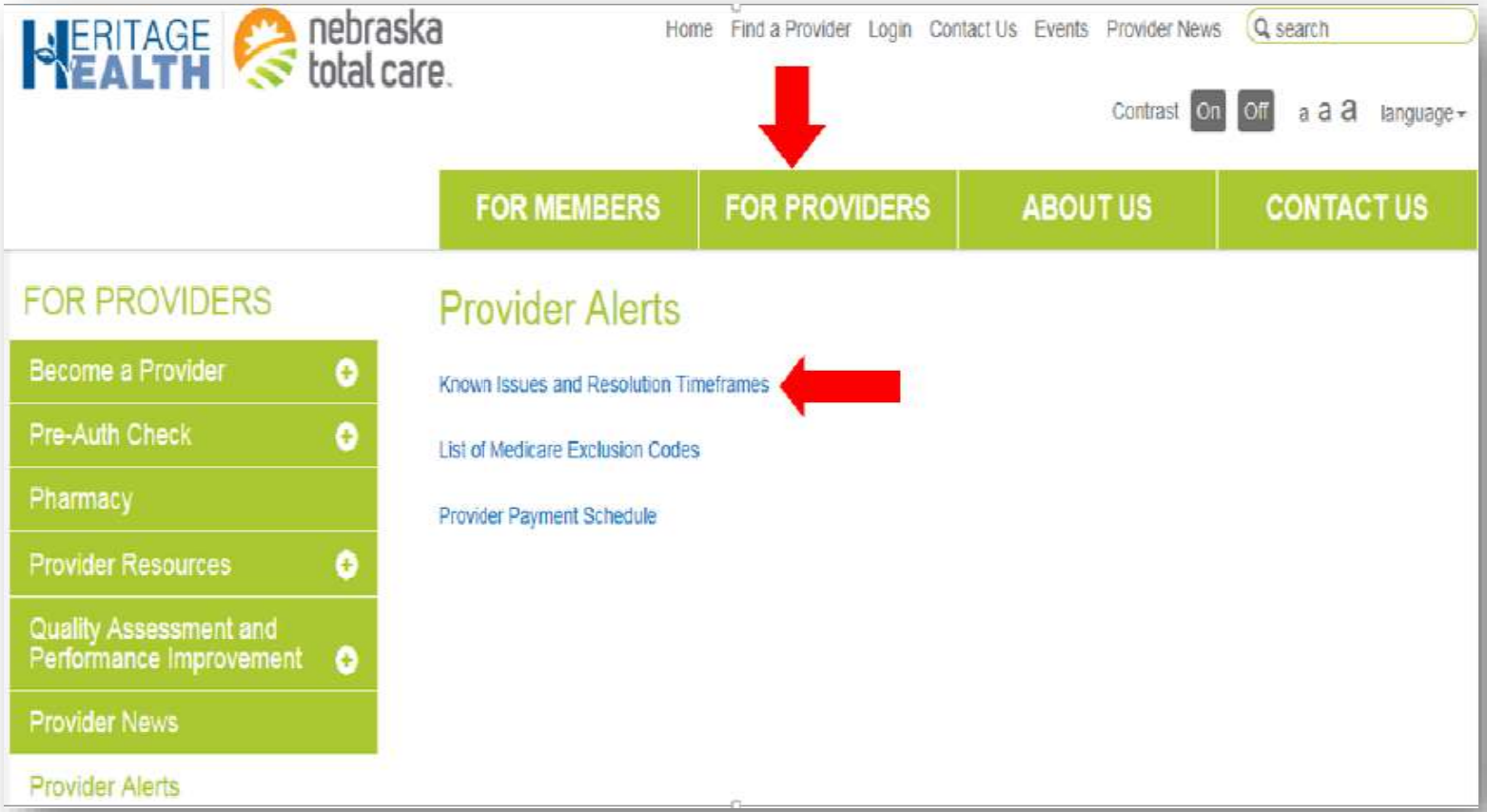
Pre-Auth Check



Pre-Auth Check

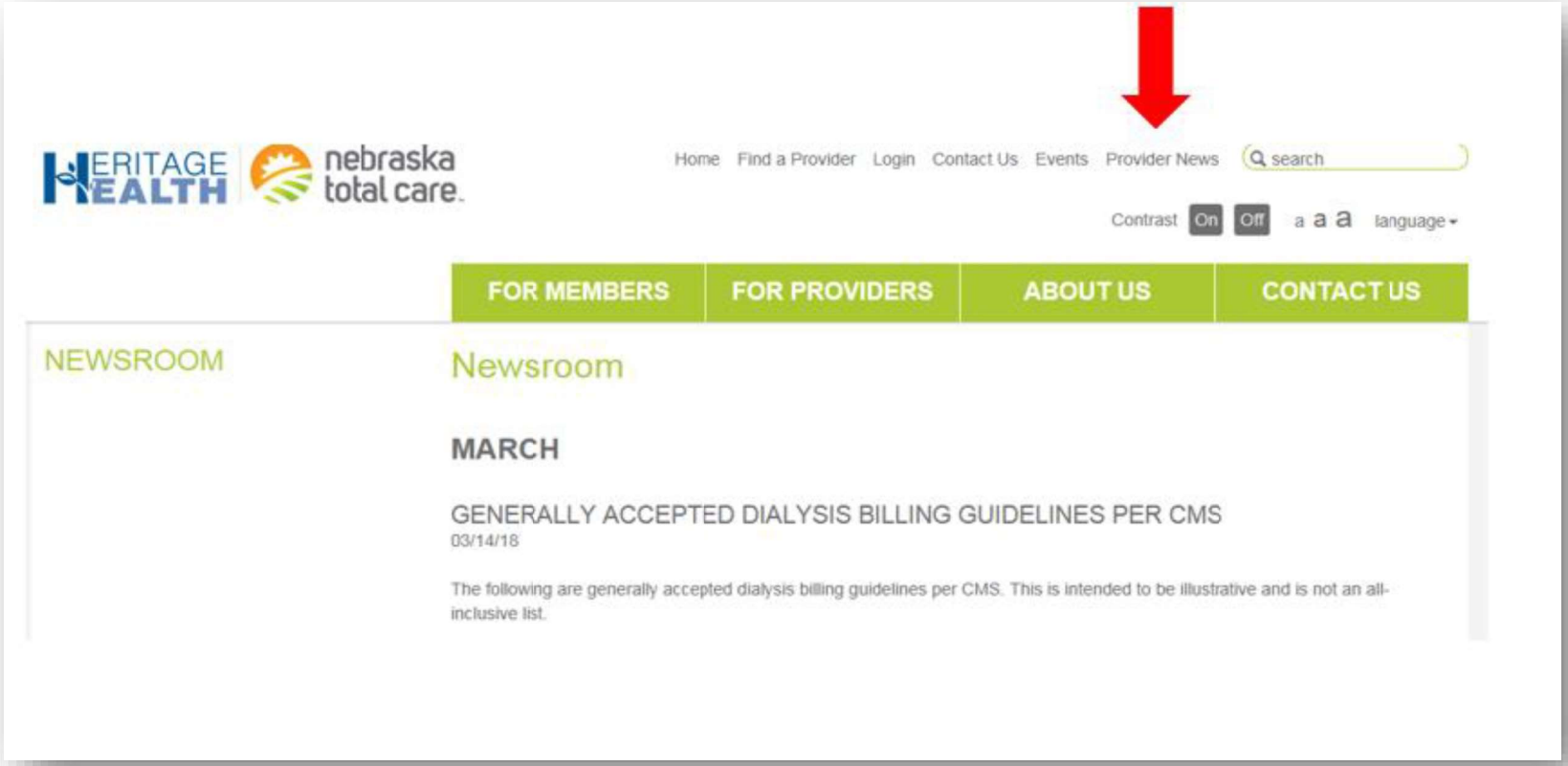


Known Issues



Provider News

Provider News allows you to stay up to date with Nebraska Total Care



Online Claim Reconsideration

Nebraska Total Care has implemented an increased functionality through our provider portal to allow providers to submit claim reconsiderations online.

The Nebraska Total Care provider portal now enables streamlined online submission of claim reconsiderations, the ability to attach supporting documentation to the reconsideration request and simple tracking of reconsideration status and completion.

Claim Reconsiderations

A Reconsideration is a request for Nebraska Total Care to review a claim with additional information submitted by the provider that was not previously submitted, or the provider is not in agreement with the denial.

Must be received 90 days from the receipt of payment/denial notification

Can be submitted by mail to Farmington along with the reconsideration form, via the web portal, or by contacting Provider Services

The standard turnaround time is 30 calendar days after the reconsideration is received.

Claim Reconsiderations & Appeals

When submitting a claim reconsideration to Nebraska Total Care, please use the identified reconsideration form as the face sheet to the reconsideration packet. It is important that this form be the top sheet submitted with a reconsideration.

Additionally, when submitting a claim appeal to Nebraska Total Care please use the identified appeal form as the face sheet to the appeal packet. It is important for claim reconsideration and claim appeal processing that these are the lead documents submitted.

When reconsidering or appealing a claim, a copy of the original claim is not required to be in the packet.

Claim Reconsiderations & Appeals

All claim reconsiderations and appeals go to:

Nebraska Total Care Health Plan
Attn: Claims Appeals/Reconsiderations
PO Box 5060
Farmington, MO 63640-5060

Claim Reconsideration Form

nebraska total care

PROVIDER RECONSIDERATION FORM

Use this form as part of the Nebraska Total Care (NTC) reconsideration process to address the decision made during the request for review process.

NOTE: All claim requests for reconsideration must be received within 90 calendar days from the date of the Medicaid Remittance. *This form should be utilized if a claim has been processed and a Medicaid Remittance Advice issued from NTC – Do not use for first time claims.*

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

All fields below are required information. Failure to complete the form may result in a delay of your request.

Reason for reconsideration Request:

All NTC claims reconsiderations must be mailed to the below address. If claims are sent to the Nebraska address in Omaha, they will be returned to the providers to resubmit to Farmington, MO. NTC does not process claims in Nebraska and will not be able to forward to Farmington for review.

Nebraska Total Care Health Plan
Attn: Claim Reconsiderations
PO Box 5060
Farmington, MO 63640-5060

NTC will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn out original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment dus will appear on the provider remittance.)

This form may be photocopied.

Claim Appeal Form

nebraska total care

PROVIDER CLAIM APPEAL FORM

Use this form as part of the Nebraska Total Care (NTC) Appeal process to address the decision made during the request for review process.

NOTE: All claim appeals must be received within 60 calendar days from the date of the Medicaid Remittance. ***This form should be utilized if a claim has been processed and a Medicaid Remittance Advice issued from NTC – Do not use for first time claims.***

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

All fields below are required information. Failure to complete the form may result in a delay of your request.

Reason for Claim Appeal Request:

An Appeal is a formal written request to NTC for review on a reconsideration that is upheld. Appeals must include medical records or medical information to support why a provider feels that claim should process for payment. Please include EOB if possible to support the claim detail you are inquiring about.

Nebraska Total Care Health Plan
Attn: Claim Appeals
PO Box 5060
Farmington, MO 63640-5060

NTC will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn out original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance.)

This form may be photocopied

What can the Provider Portal do for me?

The Secure Provider Portal offers:

- Member eligibility and patient listings
- Health records and care gaps
- Provider Analytics Tools
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history

Accessing the Web Portal

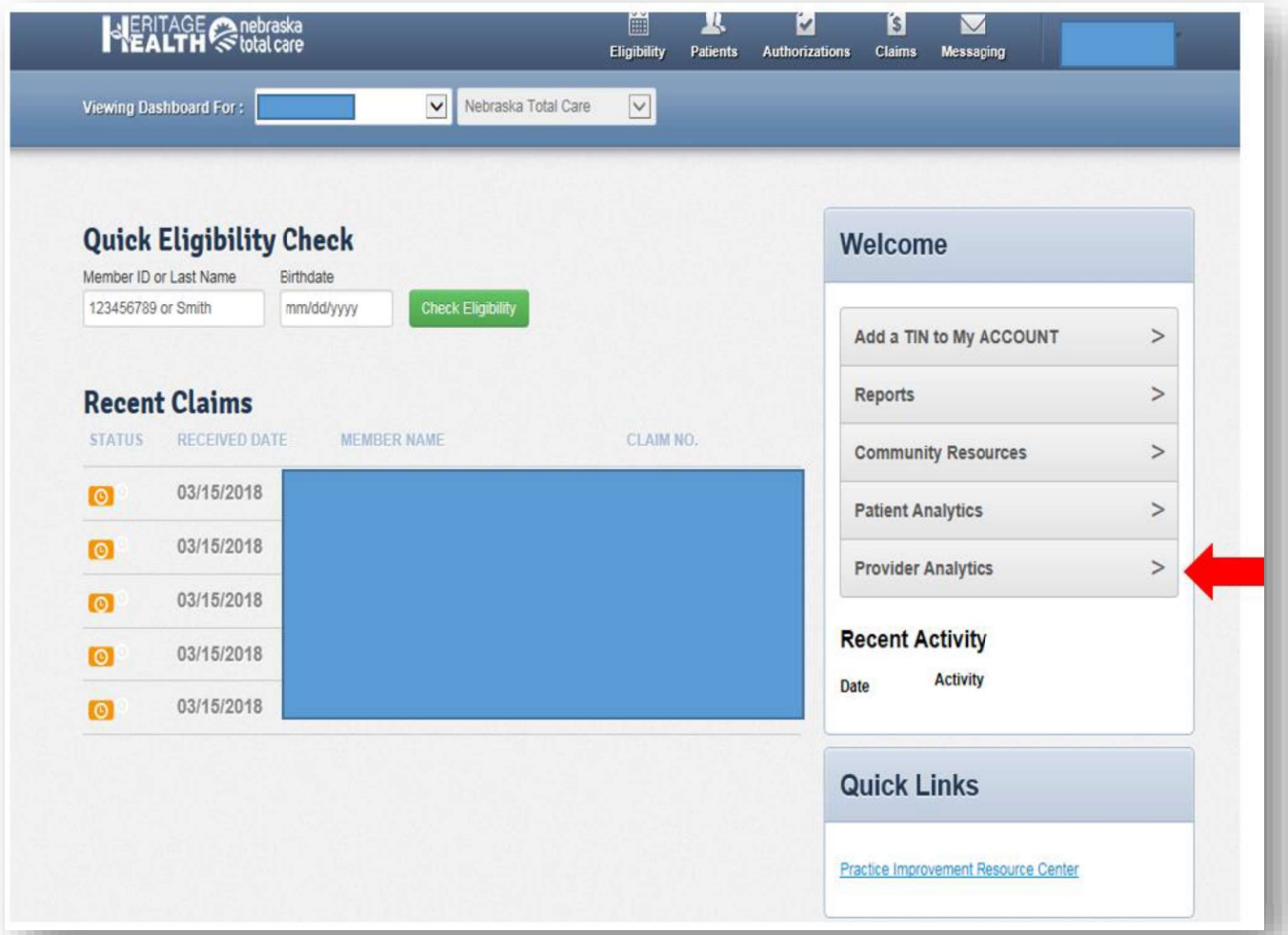
Log into your account at least once a month.

Administrator can determine what access is granted to the portal.

If account has been locked out due to inactivity, please email NEProviderRelations@NebraskaTotalCare.com to have the account reset.

Administrators are responsible for ensuring an employee's account is deactivated when they leave the organization.

Provider Analytics 2.0



Provider Analytics 2.0

Provider Analytics Enhancements

- Summary page with graphical view of member cost and utilization data
- Patient engagement analysis to understand preferences and utilization of primary care services based on claims
- Emergency Department Reporting
- Member level-drill down and reporting
- Data is refreshed every monthly

Integrated Case Management

Referral for CM comes from providers, hospitals, health plan staff, members, etc.

Case Management staff reach out to high risk members early in pregnancy.

Health Risk Screenings & Assessments (HRA, HRS)

Assistance with social determinant needs, education, care coordination, advocacy

Outreach to providers regarding members risk/ potential for 17P

- Sharing of Care Plan & Collaboration

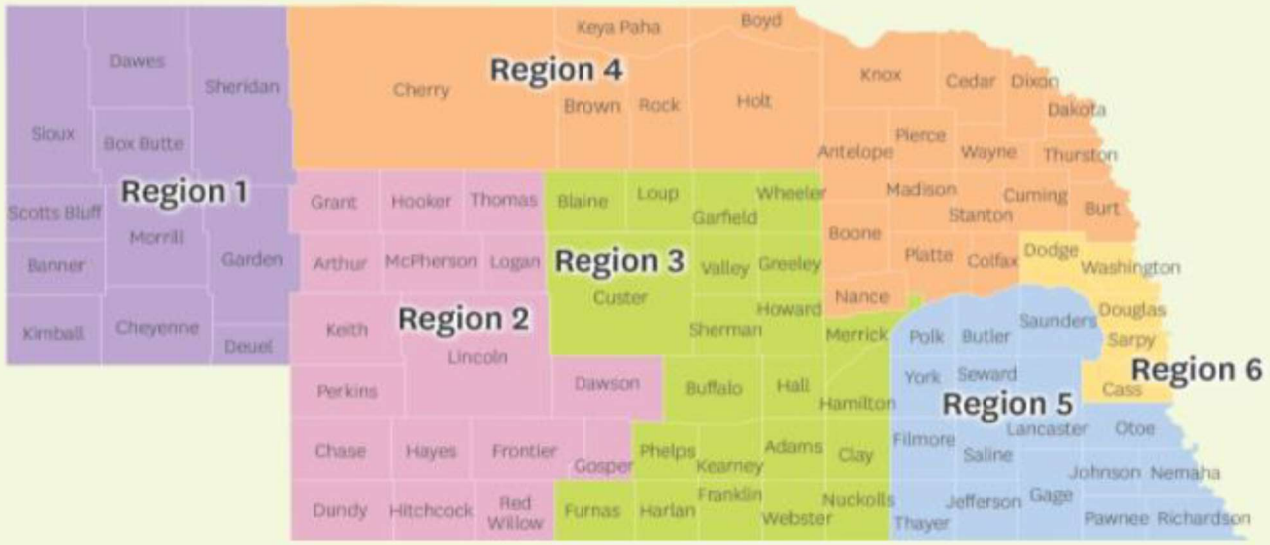
Behavioral Health

Provider Relations Map for BH

Behavioral Health Provider Relations

Mariana Johnson
Senior Manager of Provider Relations
Mariana.I.Johnson@NebraskaTotalCare.com
Cell: 402-590-9113

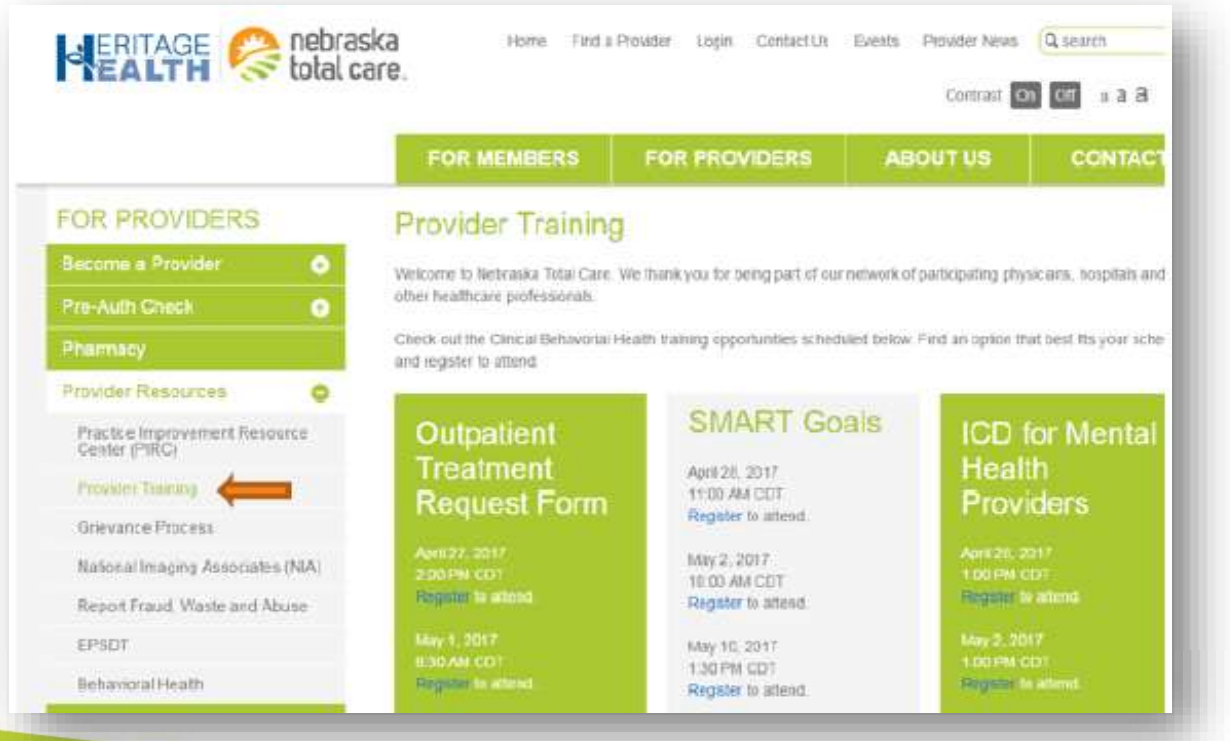
Behavioral Health Regions



Where do I find BH training opportunities?

NebraskaTotalCare.com

- For Providers
- Provider Resources



Where do I submit authorizations?

Prior authorizations can be submitted by:

- Electronically through the secure Provider Portal
- By fax

866-535-6974

Certificate of Need
Discharge summaries
Inpatient clinical documentation

866-593-1955

Outpatient treatment requests
Outpatient clinical documentation

Behavioral Health forms can be accessed at https://www.nebraskatotalcare.com/providers/resources/behavioral-health-forms.html

Thank you

RFP 112209 O3

Attachment B.43.D

HEDIS Quick Reference Guide

Quick Reference Guide

HEDIS® 2022

For more information, visit www.ncqa.org

Quick Reference Guide

WHAT IS HEDIS?

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans.

NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, healthcare providers, and policy makers.

HOW ARE RATES CALCULATED?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data.

Accurate and timely claim/encounter data (administrative) reduces the need for medical record review. If services are not billed or not billed accurately, they are not included in the calculation.

WHAT ARE THE SCORES USED FOR?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for members.

Nebraska Total Care strives to enhance quality of care through a focus on preventative and screening services while promoting engagement with our members and utilize HEDIS scores to measure impact. HEDIS scores can also be utilized to evaluate your practice's preventive care efforts.

MEDICAL RECORDS

When administrative and hybrid data are not available, organizations may use other sources to collect data about their members and about delivery of health services to members. We review medical records to find this information. Medical records may be faxed or emailed securely to the health plan. To ease burden on the provider and staff and to capture these measures throughout the year, health plans may request remote access to your EMRs.

Health plans can also receive information via Electronic Data Exchange (EDS). EDS, also referred to as supplemental data, electronically captures additional clinical information about a member, beyond *administrative* claims, that are received by Nebraska Total Care.

PAY FOR PERFORMANCE (P4P)

P4P is an activity-based reimbursement, with an incentive payment based on achieving defined and measurable goals related to access, continuity of care, member satisfaction and clinical

Quick Reference Guide

outcomes. Based on program performance, you are eligible to earn compensation in addition to what you are paid through your Participating Provider Agreement.

HOW CAN I IMPROVE MY HEDIS SCORES?

- Submit claim/encounter data for each and every service rendered
- Make sure that chart documentation reflects all services billed.
- Bill (or report by encounter submission) for all delivered services, regardless of contract status.
- Ensure that all claim/encounter data is submitted in an accurate and timely manner.
- Consider including CPT® CAT II codes to provide additional details and reduce medical record requests.
  - CPT® CAT II codes are supplemental tracking codes than can be used for performance measurement. Use of these codes will decrease the need for some record abstraction and chart review thereby minimizing administrative burdens on providers and other healthcare staff.
  - CPT® CAT II codes ensure gaps in care are closed in a timelier manner.
  - Improve accuracy of gaps-in-care reporting.
  - More effectively monitor quality and service delivery within a provider's practice.
  - They capture data that ICD-10 codes and CPT® Category I codes do not – so important information related to health outcome measures is relayed more efficiently.

HEDIS and HIPAA

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/members. The medical record review staff and/or vendor will have a signed HIPAA-compliant Business Associate Agreement.

Glossary of Terms

Numerator – The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.

Denominator – The number of members who qualify for the measure criteria, based on NCQA technical specifications.

Measurement year – In most cases, the 12-month timeframe between which a service was rendered; generally, January 1 through December 31.

Reporting year – The timeframe when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.

Quick Reference Guide

Admin

Administrative: Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.

Hybrid

Hybrid: Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters and medical record data. In some cases, health plans use auditor-approved supplemental data for the numerator.

ECDS

Electronic Clinical Data Systems (ECDS): HEDIS quality measures reported using ECDS is a secure sharing of patient medical information electronically between systems. Measures that leverage clinical data captured routinely during the care delivery can reduce the burden on providers to collect data for quality reporting.

CAHPS

CAHPS Survey: On an annual basis, the Consumer Assessment of Health Plans Survey (CAHPS) is sent to a group of randomly selected members.

Updates to HEDIS Measures (*effective for calendar year 2021 and 2022*)

This guide has been updated with information from the release of the HEDIS 2021/2022 Volume 2 Technical Specifications by NCQA and is subject to change.

Retired Measures:

Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy and HbA1c Testing Indicators.

Revised Measures:

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

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Eye Exam for Patients with Diabetes (EED)

For additional information or questions related to HEDIS, please contact the Quality Improvement Department:

Provider Services Hours: Monday through Friday, 7:00 a.m. – 8:00 p.m. CT

Provider Services Phone Number: 1-844-385-2192 (TTY: 711)

Quality Website: NebraskaTotalCare.com/providers/quality-improvement

Provider Services Website: NebraskaTotalCare.com/providers.html

Quick Reference Guide

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(AMM) Antidepressant Medication Management

Admin

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

Line of Business: Commercial, Medicaid and Medicare

Measure evaluates percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

- **Effective Acute Phase Treatment**: percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective Continuation Phase Treatment**: percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Antidepressant Medications

Description	Prescription	Prescription
Miscellaneous Antidepressants	Bupropion Vilazodone	Vortioxetine
Monoamine Oxidase Inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine
Phenylpiperazine Antidepressants	Nefazodone	Trazodone
Psychotherapeutic Combinations	Amitriptyline-chlordiazepoxide	Amitriptyline-perphenazine Fluoxetine-olanzapine
SNRI Antidepressants	Desvenlafaxine Duloxetine	Levomilnacipran Venlafaxine
SSRI Antidepressants	Citalopram Escitalopram Fluoxetine	Fluvoxamine Paroxetine Sertraline
Tetracyclic Antidepressants	Maprotiline	Mirtazapine
Tricyclic Antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6 mg)	Imipramine Nortriptyline Protriptyline Trimipramine

*Subject to change.

Quick Reference Guide

To Improve HEDIS Measure:

- Ensure members remain adherent to antidepressant medication treatment. Ongoing monitoring is critical to adherence.
- Schedule follow-up visits prior to the member leaving the office.

Quick Reference Guide

(APM) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Admin

ECDS

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

Line of Business: Commercial and Medicaid

Measure demonstrates the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during the measurement year. Both of the following are needed to be compliant: Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Antipsychotic Medications

Description	Prescription	Prescription
Miscellaneous Antipsychotic Agents	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Pimozide Quetiapine Risperidone Ziprasidone
Phenothiazine Antipsychotics	Chlorpromazine Fluphenazine Perphenazine	Thioridazine Trifluoperazine
Thioxanthenes	Thiothixene	
Long-Acting Injections	Aripiprazole Aripiprazole lauroxil Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate Risperidone

Quick Reference Guide

Antipsychotic Combination Medications

Description	Prescription
Psychotherapeutic Combinations	Fluoxetine-olanzapine Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine Antipsychotics	Prochlorperazine

Test Types

Description	Codes*
HbA1C Tests	**CPT®|CAT-II:** 83036, 83037, 3044F, 3046F, 3051F, 3052F **LOINC:** 17856-6, 4548-4, 4549-2
Glucose Tests	**CPT®|CAT-II**: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **LOINC:** 10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
LDL-C Tests	**CPT®|CAT-II**: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F **LOINC:** 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
Cholesterol Test Other than LDL	**CPT®|CAT-II:** 82465, 83718, 83722, 84478 **LOINC:** 2085-9, 2093-3, 2571-8, 3043-7, 9830-1

*Codes subject to change.

To Improve HEDIS Measure:

- Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service.
- The use of CPT® Category II codes and supplemental data helps identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.
- Go to NebraskaTotalCare.com for additional resources on care management for individuals with behavioral health problems.

Quick Reference Guide

(APP) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Admin

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

Line of Business: Commercial and Medicaid

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment (90 days prior to new prescription through 30 days after).

Antipsychotic Medications

Description	Prescription	Prescription
Miscellaneous Antipsychotic Agents	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Pimozide Quetiapine Risperidone Ziprasidone
Phenothiazine Antipsychotics	Chlorpromazine Fluphenazine Perphenazine	Thioridazine Trifluoperazine
Thioxanthenes	Thiothixene	
Long-Acting Injections	Aripiprazole Aripiprazole lauroxil Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate Risperidone

*Subject to change. Not all inclusive; see current HEDIS tech specs for specific medications.

Antipsychotic Combination Medications

Description	Prescription*
Psychotherapeutic Combinations	Fluoxetine-olanzapine Perphenazine-amitriptyline

*Subject to change.

Quick Reference Guide

Psychosocial Care

CPT®|CAT-II	HCPCS
90832, 90833, 90834, 90836 -90840; 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880	G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485

To Improve HEDIS Measure:

- Psychosocial care, which includes behavioral interventions, psychological therapies, and skills training, among others, is the recommended first-line treatment option for children and adolescents diagnosed with nonpsychotic conditions such as attention-deficit disorder and disruptive behaviors.
- When prescribed, antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.
- Periodically review the ongoing need for continued therapy with antipsychotic medications.
- Provide credible sources to address any fears and stigma surrounding treatment.
- Offer a culturally competent environment – understanding a patient's culture and belief system can help distinguish what type of treatment they are seeking.

Quick Reference Guide

(COU) Risk of Continued Opioid Use

Admin

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

Line of Business: Commercial, Medicaid and Medicare

The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

NOTE:

- Data is captured utilizing pharmacy claims data for opioid medications filled.
- The age population starts for members 18 years and older as of November 1 of the year prior to the measurement year.
- Inverse measure, so lower rate indicates better performance.

Members in hospice are excluded.

Risk of Continued Opioid Use

Description	Codes*
Hospice Encounter (exclusion)	**HCPCS:** Q5004-Q5010

*Codes subject to change

To Improve HEDIS Measure:

- Work with patients who are ready to cut down on use to develop a treatment plan.
- Assist patients with identifying alternative pain management methods to lower their risk of developing dependence on opioids.
- Review the Prescription Monitoring Program Registry before prescribing opioids.
- Use the lowest effective dose of opioids for the shortest period of time needed.
- Establish follow-up appointments to assess pain management.

Quick Reference Guide

(FUA) Follow-Up After Emergency Department Visit for Substance Use

Admin

Summary of Changes: *Change in name of the measure. *Added ED visits with a diagnosis of unintentional and undetermined drug overdose to the denominator. *Revised the measure name from Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence to Follow-Up After Emergency Department Visit for Substance Abuse.

Line of Business: Commercial, Medicaid and Medicare

The percentage of Emergency Department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

A telephone visit, e-visit, or virtual check-in for principal diagnosis of AOD or dependence is acceptable.

Follow-up Visits

Description	Codes*
Outpatient Visit with an Outpatient or Telehealth Setting	**CPT®:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
Behavioral Health Visit	**CPT®:** 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 **HCPCS:** G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Quick Reference Guide

Description	Codes*
Behavioral Health Assessment	**CPT®:** 99408, 99409 **HCPCS:** G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
7-day follow-up indicator	**CPT®:** 99496
30-day follow-up indicator	**CPT®:** 99495
Telephone Visits	**CPT®:** 98966, 98967, 98968, 99441, 99442, 99443

*Codes subject to change

To Improve HEDIS Measure:

- Explain the importance of follow-up to your patients. Reach out to patients that do not keep initial follow-up appointments and reschedule them ASAP.
- A principal diagnosis of substance use disorder or any diagnosis of drug overdose must be used to meet follow-up criteria.
- A telehealth visit with a principal diagnosis of substance use disorder or drug overdose will meet criteria for a follow-up visit.
- If you are seeing the patient for multiple issues, the substance use disorder or drug overdose diagnosis must be listed as the principal diagnosis to meet compliance for this measure.
- Work with local hospital emergency departments to obtain data exchange reports on your patient's seen in the ER for better care coordination.
- If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit.

Quick Reference Guide

(FUH) Follow-Up After Hospitalization for Mental Illness

Admin

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

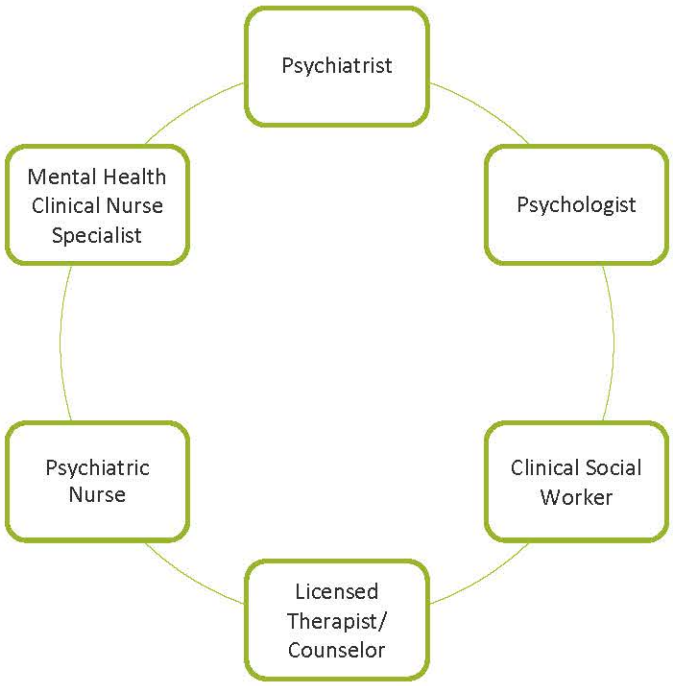
Line of Business: Commercial, Medicaid and Medicare

Measure evaluates percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit **with a mental health provider**. Two rates are reported:

- Discharges for which the member received follow-up within 7 days after discharge.
- Discharges for which the member received follow-up within 30 days after discharge.

Note: Visits that occur on the date of discharge will not count toward compliance. Telehealth visits with a behavioral health provider are acceptable to address the care opportunity.

Types of Mental Health/Behavioral Health Providers:



Quick Reference Guide

Follow-up Visits

Description	Codes*
Visit Setting Unspecified Value Set with Outpatient POS with Mental Health Provider	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit with Mental Health Provider	**CPT®:** 98960 - 98962, 99078, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99341 - 99345, 99347 – 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99510, 99483 **HCPCS:** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, T1015
Visit Setting Unspecified Value Set with Partial Hospitalization POS with Mental Health Provider	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 53
Electroconvulsive Therapy with Ambulatory Surgical Center POS/ Community Mental Health Center POS/ Outpatient POS/ Partial Hospitalization POS	**CPT®:** 90870 Ambulatory POS: 24 **Comm. POS**: 53 **Partial Hosp. POS:** 52 **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72, 52
Telehealth Visit	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 02
Observation	**CPT®:** 99217-99220
Transitional Care Management	**CPT®:** 99495, 99496

*Codes subject to change

Quick Reference Guide

To Improve HEDIS Measure:

- Visit must be with a mental health provider.
- Telehealth services, completed by a qualified mental health provider, do count for this HEDIS measure.
- Schedule a follow-up appointment for the patient before discharge.
- Ensure appropriate coding to capture services provided within the appropriate timeframe.
- Nebraska Total Care has resources to conquer common barriers for follow-up care for members including:
  - Transportation.
  - Interpreter needs.
  - Equipment needed for telehealth visit (cell phone, etc.).
- Refer hospitalized members to the Transitions of Care team who assist members with needed services upon discharge from the inpatient setting.

Quick Reference Guide

(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder

Admin

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

Line of Business: Commercial, Medicaid and Medicare

The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Follow-up Visits

Description	Codes*
Outpatient Visit for Substance Use Disorder	**CPT®:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
BH Visit with Substance Use Disorder	**CPT®:** 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510. **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Quick Reference Guide

Description	Codes*
Telehealth Visits	**CPT®:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **POS:** 02

*Codes subject to change

To Improve HEDIS Measure:

- This visit can be with any practitioner.
- Visits may not occur on the same date of discharge.
- Visits must have a principal diagnosis of substance use disorder.
- The member is age 13 years and older as of the date of discharge, stay or event.
- Consider screening members for a personal or family history of substance use.
  - If substance abuse is identified, schedule appropriate treatment, and explain the importance of follow-up to your patients.
- Telehealth, e-visits and virtual check-ins can be used for both the 7- and 30-day follow-up visit.

Quick Reference Guide

(FUM) Follow-Up After Emergency Department Visit for Mental Illness

Admin

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

Line of Business: Commercial, Medicaid and Medicare

The percentage of Emergency Department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for which the member received follow-up within 7 days after discharge (8 total days).
- Percentage of ED visits for which the member received follow-up within 30 days after discharge (31 total days).

Follow-up Visits

Description	Codes*
Behavioral Health Visits	**CPT®:** 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
Partial Hospitalization/Intensive Outpatient Visits	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified Value Set with Partial Hospitalization with any Practitioner	**CPT®:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **POS**: 52
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 53

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Description	Codes*
Electroconvulsive Therapy with any Practitioner Type	**CPT®:** 90870 **ICD CM:** GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
Telehealth Visit	**CPT®:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 02
Observation	**CPT®:** 99217-99220

*Codes subject to change

To Improve HEDIS Measure:

- Explain the importance of follow-up to your patients.
- Reach out to patients that do not keep initial follow-up appointments and reschedule them ASAP.
- A telehealth visit with a principal diagnosis of a mental health disorder or intentional self-harm will meet criteria for a follow-up visit.
- The follow-up can be with any type of provider to meet compliance. The principal diagnosis for the visit must be a mental health disorder or intentional self-harm.
- Collaborate with health plan case management on assisting with social determinants that may affect compliant follow-up visits.

Quick Reference Guide

(HDO) Use of Opioids at High Dosage

Admin

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

Line of Business: Commercial, Medicaid and Medicare

Proportion of members ages 18 and older receiving prescription opioids at high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

- MME: Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic.
  - A daily dose is calculated using the units per day, strength and the MME conversion factor (different for each drug).
  - A total sum of daily doses is calculated in order for an average daily dose to finally be calculated, representing all opioids dispensed to the member.

Opioid Medications

Opioid Medications	Opioid Medications	Opioid Medications
Benzhydrocodone	Fentanyl nasal spray	Opium
Butorphanol	Hydrocodone	Oxycodone
Codeine	Hydromorphone	Oxymorphone
Dihydrocodeine	Levorphanol	Pentazocine
Fentanyl oral spray	Meperidine	Tapentadol
Fentanyl buccal or sublingual tablet, transmucosal lozenge	Methadone	Tramadol
Fentanyl transdermal film/patch	Morphine	

To Improve HEDIS Measure:

- Information to help you stay informed about the latest opioid research and guidelines is also available at cdc.gov, hhs.gov or the NE Health and Human Services.
- Use the lowest dosage of opioids in the shortest length of time possible.
- Review the member's history of controlled substance prescriptions using the state prescription drug monitoring program data.
- Evaluate benefits and potential negative side effects with patients within 1–4 weeks of starting opioid therapy for chronic pain or dose escalation. Schedule a follow-up appointment before they leave the office.

Quick Reference Guide

- HDO is calculated as an inverse measure therefore a lower rate is desirable. A member "passes" the measure when the average daily dose of MME is < 90.

Quick Reference Guide

(IET) Initiation and Engagement of Substance Abuse Disorder Treatment

Admin

Summary of Changes: The name of the measure changed from Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment to Initiation and Engagement of Substance Abuse Disorder Treatment.

Line of Business: Commercial, Medicaid and Medicare

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement of members 13 years and older.

Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.

Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

To Improve HEDIS Measure:

- For the follow-up treatments, include an ICD-10 diagnosis for SUD, along with a procedure code for the preventive service, evaluation and management consultation or counseling service.
- Initiation of SUD treatment must take place within 14 days of the episode date.
- Claims must include the visit code, original episode diagnosis and, when applicable, a place of service code.
- Discuss the importance of timely, recommended follow-up visits with patients.
- Use the same diagnosis for substance use at each follow-up.
- Reach out to members who cancel appointments as soon as possible and assist them with rescheduling them.

Quick Reference Guide

(POD) Pharmacotherapy for Opioid Use Disorder

Admin

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

Line of Business: Commercial, Medicaid and Medicare

The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD.

Opioid Use Disorder Treatment Medications

Description	Medications
Antagonist	Naltrexone (oral or injectable)
Partial Agonist	Buprenorphine (sublingual tablet, injection, implant)
Partial Agonist	Buprenorphine (sublingual tablet), Buprenorphine (injection), Buprenorphine (implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)
Agonist	Methadone (oral) is only acceptable when billed on a medical claim. A pharmacy claim would be indicative of treatment for pain rather than OUD.

To Improve HEDIS Measure:

To promote compliance and encourage treatment for a minimum of 180 days:

- Patients with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.
- Identify and address any barriers to member:
  - Keeping appointments.
  - Timely medication refills.
- Provide reminder calls to confirm appointment.
- Utilize member benefits from health plan, such as transportation or cell phones for telehealth visits.
- Provide timely submission of claims.

Quick Reference Guide

(SAA) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Admin

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

Line of Business: Commercial, Medicaid, Medicare

Percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of the treatment period.

Antipsychotic Medications

Drug Category	Medications	Medications
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Quetiapine Risperidone Ziprasidone
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine Perphenazine	Prochlorperazine Thioridazine Trifluoperazine
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	
Thioxanthenes (oral)	Thiothixene	
Long-acting injections 30-day supply	Risperidone (Perseris)	
Long-acting injections 28-day supply	Aripiprazole Aripipzole lauoxil Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate
Long-acting injections 14-day supply	Risperidone (excluding Perseris)	

To Improve HEDIS Measure:

- Outreach directly to members who were recently prescribed antipsychotics or who have refills that are past due to confirm that they are taking their medications.

Quick Reference Guide

- Offer tips to patients, such as:
  - Taking medication at the same time each day,
  - Use a pill box,
  - Encourage patients to enroll in auto refill programs at their pharmacy,
  - Discuss potential side effects and encourage member to contact provider and not stop usage.
- Avoid giving samples; only prescriptions with a pharmacy claim are utilized to measure adherence.
- Assess if long-acting injectable is appropriate.

Quick Reference Guide

(SMD) Diabetes Monitoring for People with Diabetes and Schizophrenia

Admin

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

Line of Business: Medicaid Only

Percentage of members ages 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1C test during the measurement year.

Member must have both tests to be compliant with the measure. The organization may use a calculated or direct LDL.

Diabetes Testing Codes

Description	CPT®	CPT®|CAT II
HbA1c	83036, 83037	3044F, 3046F, 3051F, 3052F
LDL-C	80061,83700, 83701,83704, 83721	3048F, 3049F, 3050F

To Improve HEDIS Measure:

- Member must have both tests to meet this measure. Use appropriate documentation and correct coding.
- Teach the patient the need for follow-up appointments to empower shared decision-making between the provider and the patient.
- Ensure quality communication between behavioral and primary care providers in the coordination of care.
- Schedule an annual A1C and LDL-C test.
- Maintain appointment availability for patients with immediate concern.
- Outreach to patients that cancel appointments and reschedule as soon as possible.
- Collaborate with health plan case management on assisting with social determinants

Quick Reference Guide

(SSD) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Admin

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

Line of Business: Medicaid Only

Percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes Screening

Description	CPT®	CPT®|CAT-II	LOINC
HbA1c Test	83036, 83037	3044F, 3046F, 3051F, 3052F	17856-6, 4548-4, 4549-2
Glucose Test	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951		10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7

*Codes subject to change.

To Improve HEDIS Measure:

- **Use appropriate documentation and correct coding.**
- Teach the patient the need for follow-up appointments to empower shared decision-making between the provider and the patient.
- Ensure quality communication between behavioral and primary healthcare providers in the coordination of care.
- Maintain appointment availability for patients.
- Outreach to patients that cancel appointments and reschedule as soon as possible.
- Collaborate with health plan case management on assisting with social determinants.
- Schedule an annual glucose or A1c test.

Quick Reference Guide

(UOP) Use of Opioids from Multiple Providers

Admin

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

Line of Business: Commercial, Medicaid and Medicare

The proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year, who received opioids from multiple providers. Three rates are reported:

Three rates are reported:

- **Multiple Prescribers**. The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
- **Multiple Pharmacies.** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
- **Multiple Prescribers and Multiple Pharmacies.** The proportion of members receiving prescriptions for opioids from four or more different prescribers **and** four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Note: A lower rate indicates better performance for all three rates.

Opioid Medications	Opioid Medications
Buprenorphine transdermal patch	Meperidine
Buprenorphine buccal film	Methadone
Butorphanol	Morphine
Codeine	Opium
Dihydrocodeine	Oxycodone
Fentanyl	Oxymorphone
Hydrocodone	Pentazocine
Hydromorphone	Tapentadol
Levorphanol	Tramadol

*Subject to change

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To Improve HEDIS Measure:

- Information to help you stay informed about the latest opioid research and guidelines is also available at cdc.gov, hhs.gov or the Nebraska public health department website.
- Utilize the prescription drug monitoring program (PMP).
- Consider creating a patient/provider opioid/pain contract regarding agreement that patient utilizes only one prescriber and one pharmacy.
- Assist patient with identifying alternative pain management methods to lower their risk of developing opioid dependence.

Quick Reference Guide

(CBP) Controlling High Blood Pressure

Admin/ Hybrid

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

Line of Business: Commercial, Medicaid and Medicare

Measure evaluates the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Note: The blood pressure reading must be taken during an outpatient visit, telephone visit, e-visit or virtual check in, a non-acute inpatient encounter, or remote monitoring event. Measurement taken by the member using a non-digital device such as with a manual blood pressure cuff and stethoscope are not acceptable.

Controlling High Blood Pressure

Description	Codes
Hypertension	**ICD-10:** I10
Systolic Greater Than/Equal to 140	**CPT®|CAT-II:** 3077F
Systolic Less Than 140	**CPT®|CAT-II:** 3074F, 3075F
Diastolic Greater Than/Equal to 90	**CPT®|CAT-II:** 3080F
Diastolic 80–89	**CPT®|CAT-II:** 3079F
Diastolic Less Than 80	**CPT®|CAT-II:** 3078F
Outpatient Codes	**CPT®:** 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Non-Acute Inpatient Codes	**CPT®:** 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337
Telephone Visits	**CPT®:** 98966, 98967, 98968, 99441, 99442, 99443
Online Assessments	**CPT®:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457

*Codes subject to change.

To Improve HEDIS Measure:

- BP reading must be the last performed within the measurement year.
- BP readings reported by and taken by a member are acceptable, apart from a non-digital manual device.

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- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading.
- The use of CPT® Category II codes helps to identify clinical outcomes such as systolic and diastolic BP readings. It can also reduce the need for some chart review.
- The measure looks at the lowest systolic and the lowest diastolic reading. If the initial BP is > 139/89, retake it and record each reading in the medical record.

Quick Reference Guide

(CRE) Cardiac Rehabilitation

Admin

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

Line of Business: Commercial, Medicaid and Medicare

Measure evaluates percentage of members 18 and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement following a qualifying cardiac event between July 1 of year prior to measurement year and June 30 of measurement year.

Four rates are reported:

- **Initiation**: percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- **Engagement 1**: percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after qualifying event.
- **Engagement 2:** percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after qualifying event.
- **Achievement**: percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after qualifying event.

Cardiac Rehabilitation

Description	Codes
Cardiac Rehabilitation	**CPT®:** 93797, 93798 **HCPCS:** G0422, G0423, S9472

*Codes subject to change.

To Improve HEDIS Measure:

- Transportation (non-emergency) may be available for rides to the member's rehabilitation sessions.

Quick Reference Guide

(SPC) Statin Therapy for Patients with Cardiovascular Disease

Admin

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

Line of Business: Commercial, Medicaid and Medicare

Percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

- **Received statin therapy:** Members who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.
- **Statin adherence 80 percent:** Members who remained on a high- or moderate-intensity statin medication 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 at least moderate intensity through the last day of the measurement year.

Statin Therapy Medications

Drug Category	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 Pitavastatin 1–4 mg Pravastatin 40–80 mg Rosuvastatin 5–10 mg Simvastatin 20–40 mg

*Subject to change.

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.

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- Offer tips to patients such as:
  - Taking medication at the same time each day,
  - Use a pill box,
  - Discuss potential side effects and encourage member to contact provider and not stop usage.

Quick Reference Guide

(ADD) Follow-Up Care for Children Prescribed ADHD Medication

Admin

ECDS

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

Line of Business: Commercial and Medicaid

The percentage of children ages 6–12 newly prescribed an ADHD medication that had **at least three** follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The visit should be with a practitioner with prescribing authority. Two rates are reported:

- **Initiation Phase:**
  - A follow-up visit with the prescribing practitioner must be within 30 days after the date the ADHD medication was newly prescribed.
- **Continuation and Maintenance (C&M) Phase:**
  - Members 6–12 years of age who remained on the dispensed ADHD medication for at least 210 days and in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase ended.
    - One of the two visits may be a telephone or telehealth visit with the prescribing practitioner.

To Improve HEDIS Measure:

- Prescribe only one month of medication to ensure member returns to office within 30 days.
  - Consider scheduling all three follow-up appointments prior to leaving the office:
    - Within 30 days of the new prescription.
    - Three months.
    - Six to nine months.

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- Educate the child and caretakers about the need to reevaluate whether the medications are working as intended after 2–3 weeks, and to regularly monitor the effects afterward.
- Submit the correct CPT® codes.
- Utilize telehealth as on option for improving compliance.
- Only one Continuation Phase visit can be an e-visit or virtual check in.
- Utilize the ADHD Appointment Card from Nebraska Total Care:
  - List of common side effects to monitor.
  - Behavior checklist (ADHD Parent Screen).
  - Most recent school update.

Quick Reference Guide

(CIS) Childhood Immunization Status

Admin/ Hybrid

ECDS

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

Line of Business: Commercial and Medicaid

This measure demonstrates the percentage of children 2 years of age who completed all recommended immunizations on or before child's second birthday.

NOTE: If the child is 2 years and 1 day old, services will not count towards HEDIS scores. Parental refusal is not a valid exclusion. If the member has history of anaphylactic reaction due to vaccination, the appropriate codes should be used to account for this.

To Improve HEDIS Measure:

- Check compliance with immunizations and lead screening at 18-month well-child visit (not 2 years old).
- Schedule a visit to "catch up" on immunizations and lead screenings.
- Encourage and offer flu shots during the months of September through April.
- Complete overdue immunizations at sick visits as medically appropriate.
- If history of anaphylaxis to an immunization/immunization, submit appropriate codes.
- When documenting the rotavirus vaccine, always include "Rotarix®" or "two-dose," or "RotaTeq®" or "three-dose" with the date of administration.
  - If medical record documentation doesn't indicate whether the two-dose schedule or three-dose schedule was used, it is assumed that the three-dose regimen was used.
- For parents hesitant to give all vaccines on schedule, remind them that the schedule is timed when it works best with a child's immune system.

Quick Reference Guide

(IMA) Immunizations for Adolescents

Admin/ Hybrid

ECDS

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

Line of Business: Commercial and Medicaid

Measure evaluates percentage of adolescents 13 years of age who completed immunizations on or before member's 13th birthday.

Meningococcal	Tdap	HPV
1 dose on or between 11th & 13th birthday	1 dose on or between 10th & 13th birthday	2–3 doses* between 9th & 13th birthdays

**HPV: Either of the following meet the criteria:*

- *At least two HPV vaccines, on or before the member's 9th and 13th birthdays and with dates of service at least 146 days apart.*
- *At least three HPV vaccines, with different dates of services on or before a member's 9th and 13th birthdays.*

To Improve HEDIS Measure:

- Documentation that a member is up to date with all immunizations but doesn't include a list of the immunizations and dates they were administered, will NOT meet compliance.
- Parental refusal of vaccinations will not remove an eligible member from the denominator.
- Overdue immunizations can be administered at sick visits (as medically appropriate).
- When discussing vaccines with members and their parents, recommend the HPV vaccine in the same way and at the same visits as the Tdap and meningococcal vaccine.
- Vaccination information is available for members on the Nebraska Total Care website in the Krames Health Library . They can be printed off and provided to parents/guardians.
- If history of anaphylaxis to an immunization/immunization, submit appropriate codes.

Quick Reference Guide

(LSC) Lead Screening in Children

Admin/ Hybrid

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

Line of Business: Medicaid Only

Measure evaluates percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Lead Testing

Description	Codes
CPT® | CAT II	83655
LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7

*Codes subject to change.

To Improve HEDIS Measure:

- Lead screening must be performed on or before the child's 2nd birthday to be compliant.
- Medical Record documentation must have a note with date of the test performed and the result or findings.
- A lead risk assessment does not satisfy the venous blood lead requirement for Medicaid members, regardless of the risk score.
  - EPSDT: Blood lead testing is required at 12 months and 24 months for all Medicaid-eligible children regardless of the responses to the questions in the lead screening assessment.
- Educate parents about the major sources of lead and poisoning prevention.
- Conduct necessary follow-up and explain to parents why follow-up is needed.
- Additional resources on lead screening can be found on the Nebraska Total Care website.

Quick Reference Guide

(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Admin/ Hybrid

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

Line of Business: Commercial and Medicaid

This measure demonstrates the percentage of members ages 3–17 who had an outpatient visit with a primary care provider or OB-GYN and had evidence of the following during the measurement year:

- Body mass index (BMI) percentile.
- Counseling for nutrition.
- Counseling for physical activity.

Note: Services rendered for obesity or eating disorders will meet criteria for the counseling for nutrition and counseling for physical activity indicators.

Weight Assessment and Counseling

Description	Codes
BMI Percentile	**ICD-10**: Z68.51-Z68.54 **LOINC:** 59574-4, 59575-1, 59576-9
Nutrition Counseling	**CPT®|CAT II:** 97802- 97804 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470 **ICD-10**: Z71.3
Physical Activity Counseling	**HCPCS:** G0447, S9451 **ICD-10**: Z02.5, Z71.82

*Codes subject to change.

To Improve HEDIS Measure:

- Make sports/day care physicals into well-care visits by performing the required services and submitting appropriate codes.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide education on physical activity and nutrition and BMI percentile calculations.
- Documentation must include height, weight and BMI percentile documented in the medical record or plotted on a BMI age-growth chart.
- Handouts given during a visit ***without evidence of a discussion*** does not meet the criteria for health education/anticipatory guidance.
- Schedule the next annual exam prior to leaving the office.
- Use of appropriate codes may close the gap in care, therefore reducing need for medical record review. See table above for examples.

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(W30) Well-Child Visits in the First 30 Months

Admin

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

Line of Business: Commercial and Medicaid

The percentage of members who had the following number of well-child visits with a PCP. The following rates are reported:

- Well-child visits in the first 15 months (children who turn 15 months in the measurement year).
  - Six or more well-child visits.
- Well-child visits age 15–30 months (children who turn 30 months in the measurement year).
  - Two or more well-child visits.

Components of a comprehensive well-child visit include:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Visits must be with a PCP and assessment or treatment that are specific to an acute or chronic condition do not count towards the measure. Be sure to use age-appropriate codes.

Well-Care Visits

CPT®|CAT II	HCPCS	ICD-10
99381–99385, 99391–99395, 99461	G0438, G0439, S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.2

*Codes subject to change.

To Improve HEDIS Measure:

- Ensure documentation includes all appropriate screening requirements.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National

Quick Reference Guide

Center for Education in Maternal and Child Health). Reference the American Academy/Bright Futures site for additional guidance on appropriate documentation.

- Appropriate coding for the member's age will ensure the visit is captured through claims.
- Check immunization records at every visit to ensure shots are up to date for children on or before their 2nd birthday.
- Ensure 2 blood lead **levels** are completed before the 2nd birthday (all members on Medicaid are considered at risk for lead exposure and should be tested).
- Handouts are acceptable *only* if there is evidence of discussion.

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(WCV) Child and Adolescent Well-Care Visits

Admin

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

Line of Business: Commercial and Medicaid

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or OB-GYN practitioner during the measurement year.

Components of a comprehensive well-care visit include:

Well-Care Visits

CPT®|CAT II	HCPCS	ICD-10
99381–99385, 99391–99395, 99461	G0438, G0439, S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.2

To Improve HEDIS Measure:

- A PCP must complete well-child visit but it doesn't has to be the assigned PCP.
- Make sports/day care physicals into well-care visits by performing the required services and submitting appropriate codes.
- Handouts given during a visit without evidence of discussion does not meet the criteria for health education/anticipatory guidance.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health.) Visit the American Academy/Bright Futures site for more information about well-child visits.
- During every visit, it is important to discuss weight and BMI, current nutrition patterns and the importance of physical activity.

Quick Reference Guide

(BPD) Blood Pressure 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 blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year. Note:

- The last blood pressure reading of the measurement year is the one utilized in the measure.
- If multiple HbA1c tests were performed in the measurement year, the result from the last test is utilized.

Blood Pressure Screening

Description	Codes
Diastolic Less Than 80	**CPT®|CAT-II**: 3078F
Diastolic 80–89	**CPT®|CAT-II:** 3079F
Diastolic Greater Than/Equal To 90	**CPT®|CAT-II:** 3080F
Systolic Less Than 140	**CPT®|CAT-II:** 3074F, 3075F
Systolic Greater Than/Equal 140	**CPT®|CAT-II:** 3077F

*Codes subject to change.

To Improve HEDIS Measure:

- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. **Retake the member's BP after they've had time to rest.**
- Engage Care Management to manage high-risk members and coordinate care.
- The use of CPT® Category II (CPT®|CAT-II) codes helps identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.

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(EED) Eye Exam 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) who had a retinal eye exam.

At a minimum, documentation in the medical record must include one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- A chart or photograph indicating the date when fundus photography was performed AND one of the following:
  - Evidence an eye care professional (optometrist/ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
  - Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
  - Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

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Eye Examinations

Description	Codes
Diabetic Retinal Screening with Evidence of Retinopathy	**CPT®|CAT-II:** 2022F, 2024F, 2026F
Diabetic Retinal Screening **without** Evidence of Retinopathy	**CPT®|CAT-II:** 2023F, 2025F, 2033F
Diabetic Retinal Screening **without** Evidence of Retinopathy in Prior Year	**CPT®|CAT-II:** 3072F
Unilateral Eye Enucleation with a Bilateral Modifier	**CPT®|CAT-II:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **CPT® Modifier:** 50
Unilateral Eye Enucleation – Left	**ICD-10:** 08T1XZZ
Unilateral Eye Enucleation – Right	**ICD-10:** 08T0XZZ
Automated Eye Exam	**CPT®|CAT-II:** 92229

*Codes subject to change.

To Improve HEDIS Measure:

- Ensure members are aware of potential rewards and transportation assistance.
- Engage Care Management to manage high-risk members and coordinate care.
- If no Retinopathy, then a eye exam should be completed every 2 years. If member has Retinopathy, an eye exam should be performed yearly.